

# 2017-2018

## STUDENT HEALTH BENEFIT PLAN

*Crookston, Duluth, Morris and  
Rochester campuses*



Student Health Benefits  
UNIVERSITY OF MINNESOTA



Delta Dental of Minnesota



BlueCross  
BlueShield  
Minnesota



# ANNUAL NOTIFICATIONS

## Language Access Services

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမူကတဝါကညီကိုင်နီ၊ တၢ်ကဟ့ၣ်နၢကိုင်တၢ်မၤစၢၤကလိတဖၣ်န့ၣ်လီၤ. ကိ: 1-866-251-6744 လၢ TTYအဂီၢ်, ကိ: 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهااتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專線 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

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한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສໍາລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yánílt'i'go saad bee yát'i' éí t'áájíik'e bee níká'a'doowolgo éí ná'ahoot'i'. Kojí éí béésh bee hodiílnih áqííééqíáqáqéíá. TTY biniyégo éí íáájí' béésh bee hodiílnih.

## Notice of Nondiscrimination Practices

Effective July 18, 2016

The Claims Administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. The Claims Administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

The Claims Administrator provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact the Claims Administrator at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: [Civil.Rights.Coord@bluecrossmn.com](mailto:Civil.Rights.Coord@bluecrossmn.com)
- by mail at: Nondiscrimination Civil Rights Coordinator  
Blue Cross and Blue Shield of Minnesota  
M495  
PO Box 64560  
Eagan, MN 55164-0560
- or by phone at: 1-800-509-5312

Grievance forms are available by contacting the Claims Administrator at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting the Claims Administrator at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- by phone at:  
1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Room 509F  
HHH Building  
Washington, DC 20201

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

# RIGHTS AND RESPONSIBILITIES

## ***You have the right under this plan to:***

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

## ***You have the responsibility under this plan to:***

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





## ***Important Notice From the Plan Administrator About Your Prescription Drug Coverage and Medicare***

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

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

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

### **When Can You Join A Medicare Drug Plan?**

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

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

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

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

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

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

You should also know that if you drop or lose your current coverage and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

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

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

## **For More Information About Your Options Under Medicare Prescription Drug Coverage...**

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

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

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

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



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# INTRODUCTION

This Summary Plan Description (SPD) contains a summary of the University of Minnesota—Crookston, Duluth, Morris and Rochester (System Campuses) Student Health Benefit Plan (SHBP) and benefits for International Students and Scholars effective August 21, 2017.

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

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

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

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

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

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

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

The Student Health Benefit Plan provides benefits for covered services received from eligible health care providers in the Provider Network. In-Network Providers have a contract with the Claims Administrator specific to this Plan and are providers that have entered into a specific network contract with the local Blue Cross and/or Blue Shield Plan to provide you quality health services at favorable prices. **Students and Scholars paying the mandatory Student Services Fee receive the highest level of coverage when they use system campus health services.**

The Student Health Benefit Plan also provides benefits for covered services obtained from Out-of-Network Providers. In some cases, you receive a reduced level of coverage when you use these providers. Out-of-Network Providers include Out-of-Network Participating Providers and Nonparticipating Providers. Out-of-Network Participating Providers have a network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan but are not In-Network Providers because the contract is not specific to this Plan. Rather, this is the Claims Administrator's larger open access network. Nonparticipating Providers have not entered into a network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan. **You may pay a greater portion of your health care expenses when you use Nonparticipating Providers.**

The Student Health Benefit Plan is in full compliance with the Civil Rights Restoration Act of 1987, as this law amended Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. This Student Health Benefit Plan provides pregnancy benefits on the same basis as any other temporary disability, including eligible expenses resulting from childbirth, abortion or miscarriage, or complications of pregnancy.

## CUSTOMER SERVICE

<b>Student Health Benefit Plan Administrator</b>	Office of Student Health Benefits University of Minnesota
<b>(Enrollment and eligibility verification)</b>	410 Church Street S.E., Room N323 Minneapolis, MN 55455  612-624-0627 or 1-800-232-9017 (out of area)  e-mail: <a href="mailto:umshbo@umn.edu">umshbo@umn.edu</a>  <a href="http://www.shb.umn.edu">www.shb.umn.edu</a>
<b>UMD Health Service</b>	218-726-8155
<b>Blue Cross Blue Shield of Minnesota</b>	The Claims Administrator's customer service staff is available to answer your questions about your coverage and direct your calls for prior authorization, preadmission notification, preadmission certification, and emergency admission notification. Customer service staff will provide interpreter services to assist you if needed. This includes spoken language and hearing interpreters.
<b>(Questions on coverage and claims)</b>	Monday through Friday: 7:00 a.m. - 8:00 p.m. United States Central Time  Hours are subject to change without prior notice.
<b>Customer Service Telephone Number</b>	Claims Administrator: 651-662-5004 or toll free 1-866-870-0348
<b>Blue Cross Blue Shield of Minnesota Website</b>	<a href="http://www.bluecrossmnonline.com">www.bluecrossmnonline.com</a>
<b>BlueCard Telephone Number</b>	Toll free 1-800-810-BLUE (2583) This number is used to locate providers who participate with Blue Cross and Blue Shield plans nationwide.
<b>BlueCard Website</b>	<a href="http://www.bcbs.com">www.bcbs.com</a> This website is used to locate providers who participate with Blue Cross and Blue Shield plans nationwide.
<b>Claims Administrator's Mailing Address</b>	Claims review requests, and written inquiries may be mailed to the address below:  Blue Cross and Blue Shield of Minnesota P.O. Box 64338 St. Paul, MN 55164  Prior authorization requests should be mailed to the following address:  Blue Cross and Blue Shield of Minnesota Utilization Management Department P.O. Box 64265 St. Paul, MN 55164
<b>Pharmacy Telephone Number</b>	Toll free 1-800-509-0545 This number is used to locate a participating pharmacy.

<b>Maternity Management Telephone Number</b>	Toll free 1-866-489-6948 or 651-662-1818 Call this number to enroll in the Maternity Management program.
<b>Stop-Smoking Support</b>	Toll free 1-888-662-BLUE (2583) Call to enroll in Stop-Smoking Support.
<b>Doctor on Demand</b>	The Plan offers Doctor on Demand -real-time access to doctors who can discuss your symptoms, provide a diagnosis and prescribe medications if needed. Doctor On Demand offers you a lower cost alternative to traditional office visits. See the Benefit Chart for further details.
<b>Learn to Live</b>	Learn to Live is a confidential, online mental health resource that includes assessments, self-paced digital programs and optional personalized coaching. Programs use online Cognitive Behavioral Therapy (CBT) to help individuals with issues related to stress, depression and social anxiety. Visit <a href="http://learntolive.com/partners">learntolive.com/partners</a> and enter the code "UMN" for access.

**Benefits not administered by the Claims Administrator BCBS:**

<b>Delta Dental</b>	Preventative/Periodontal and Pediatric Dental benefits administrator. Delta Dental of Minnesota Customer Service 651-406-5916 or toll free 800-53-9536 Monday through Friday: 7:00 a.m. - 7:00 p.m. CST Delta Dental Network Provider Locations: <a href="http://www.deltadentalmn.org/studentdentalplan">www.deltadentalmn.org/studentdentalplan</a>
<b>Travel Assistance, Medical Evacuation &amp; Repatriation</b>	Agents are available 24 hours a day to answer questions on medical evacuation or repatriation or provide emergency travel assistance: United Health Global 8501 LaSalle Road, Suite 200 Townson, MD 21286 <a href="http://www.uhcglobal.com">www.uhcglobal.com</a>
<b>Boynton Dental Clinic</b>	612-624-9998
<b>Faculty Dental Clinic</b>	612-626-9665
<b>Lake Superior Dental Associates</b>	218-728-6445
<b>Accidental Death &amp; Dismemberment</b>	Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, New York 10166-0188

## **SPECIAL FEATURES**

### **Maternity Management**

The Maternity Management program provides expectant mothers with education and support throughout their pregnancy. This support includes access to a specially trained Health Coach (RN) and online educational information. All pregnant women have access to the program, regardless of their risk. To request further information or to enroll call (651) 662-1818, or toll free 1-866-489-6948.

### **Stop-Smoking Support**

Stop-Smoking Support provides a behavior change program to support members that want to reduce tobacco use. This service is available to all members 18 years of age or older, including those that use smokeless tobacco products. Stop-Smoking Support is a telephone-based service designed to help you quit using tobacco your way and at your pace. To participate, call the support line at 1-888-662-BLUE (2583). A Quit Coach will work with you one-on-one to develop a personalized quitting plan that addresses your specific concerns.

### **Care Management**

If you or an eligible family member has an ongoing condition like diabetes or heart disease - or you experience a major health event or illness - you may be eligible to take advantage of Care Management programs. These programs are voluntary and confidential. A Health Coach (registered nurse or behavioral health specialist) can help you coordinate care and navigate the healthcare system, identify resources to assist you in achieving your personal health goals, and talk to you over the phone and provide you with information that is specific to your condition. Each member is matched with a primary health coach who gets to know you over time so you do not have to start over every time you call.

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

### **Online Health Assessment and Online Health Coaching Programs**

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



# ELIGIBILITY FOR DOMESTIC STUDENTS

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

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

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

## ***Health Plan Requirement, Enrollment, and Waiver Process***

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

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

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

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

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

Students participating in a **Learning Abroad** experience who were enrolled in the Student Health Benefit Plan the previous term will automatically be enrolled in the Student Health Benefit Plan for the term of their Learning Abroad experience unless they submit and are approved for a waiver. Students are only eligible for a waiver if they have become eligible for and enrolled in other comparable health plan coverage. CISI insurance for Education Abroad is not eligible for a waiver. All eligible students must complete the waiver request process by the Twin Cities campus class registration deadline.

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

## ***Enrollment Deadline***

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

## ***Late Enrollees***

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

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

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

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

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

Loss of Coverage Due to Cancellation of Classes

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

Cancellation of any or all classes resulting in the loss of eligibility for the Student Health Benefit Plan will result in coverage **being cancelled effective the date classes were dropped, resulting in a loss of eligibility**. Refunds of the cost of the Student Health Benefit Plan follow the University refund schedule as stated in the Class Fee Refund Schedule.

**IMPORTANT: Cancellation of Classes and Continuation of Coverage**

Students (and their covered dependents) cannot remain covered on the Student Health Benefit Plan if they have cancelled their classes and/or lost eligibility for the plan. The only exception to this policy is if a student obtains an approved tuition refund appeal for medical reasons from the University.

Students obtaining a tuition refund appeal for medical reasons may apply for re-enrollment on the Plan for the semester if covered on the plan the previous term. The provision to continue coverage is available to eligible students one term in an academic career. A Student Health Benefit Plan enrollment form must be filled out and turned into the Office of Student Health Benefits within one week of submission of the request for tuition refund appeal to the One Stop office. The enrollment form must be submitted with proof of tuition refund appeal and payment. Upon verification of eligibility the Office of Student Health Benefits will notify the student of the outcome of the application request via their University assigned e-mail account.

***Loss of Eligibility***

Students no longer meeting eligibility, resulting in termination of the Student Health Benefit Plan, may contact the Office of Student Health Benefits to obtain details regarding an extension of coverage. Coverage can be extended through the last day of the month in which the semester coverage ended. To elect an extension of coverage, an enrollment form along with payment of one month's premium are due by the last day of semester coverage.

In the event of intentional misrepresentation or intentional 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.

***Annual Open Enrollment and Dependent Eligibility***

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

A covered student may purchase coverage for his or her spouse, and/or dependent children.

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

Dependent children, stepchildren, and legal wards must be under the age of 26 years.

Foster children placed with you or your spouse by an authorized placement agency or by judgment decree, or other order of any court of competent jurisdiction.

Dependents must be covered within the same enrollment period that applies to the covered student or within 31 days of becoming eligible. The period of coverage for dependents will be the same as that of the covered student except for special provisions under Continuation of Coverage

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

# ELIGIBILITY FOR INTERNATIONAL STUDENTS AND SCHOLARS

## *Health Plan Coverage Mandate*

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

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

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

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

## **Enrollment**

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

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

### **Dependent Enrollment:**

A covered student or scholar must purchase coverage for his or her spouse, and/or dependent children.

**Dependents must be enrolled when the student or scholar initially is enrolled on the Student Health Benefit Plan or within 31 days of arrival or becoming eligible for the plan. If the Student Health Benefit Plan Administrator does not receive the application when the student or scholar initially is enrolled or more than 31 days after arrival or becoming eligible for the plan, that student or scholar will have to pay premiums retroactive according to the University policy, to the date he or she was required to enroll.**

Foster children placed with you or your spouse by an authorized placement agency or by judgment decree, or other order of any court of competent jurisdiction. Dependent children, stepchildren, and legal wards must be under the age of 26 years and declared as dependents on the covered student's I-20 form or J Visa. Dependents must be covered within the same enrollment period that applies to the covered student or scholar or within 31 days of becoming eligible. The period of coverage for dependents will be the same as that of the covered student or scholar except for special provisions under Continuation of Coverage.

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

# ADDING DEPENDENTS

## Newborn Children

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

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

## Adding spouse and/or stepchildren

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

### Domestic Students:

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

### International Students and Scholars:

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

## Adding newborns, children placed for adoption or foster care, and court ordered dependents

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

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

### Domestic Students:

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

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

### International Students and Scholars:

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

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

## **Adding disabled children or disabled dependents**

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

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

### Domestic Students:

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

### International Students and Scholars:

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

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

If you are disputing a determination concerning an eligibility, enrollment, or other administrative issue, you may also contact the Office of Student Health Benefits (OSHB) directly, by telephone (612-624-0627 or 1-800-232-9017), fax (612-626-5183), or by mail to Office of Student Health Benefits, University of Minnesota, 410 Church Street S.E., N323, Minneapolis, MN 55455. You must contact the Office of Student Health Benefits within 30 days of the date that the eligibility, enrollment, or other administrative issue first became apparent.

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

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

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

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

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

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

# STUDENT HEALTH BENEFIT PLAN HIGHLIGHTS

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

## Coverage Dates and Costs

Semester	Dates of Coverage	Student	Spouse	Child	Children
Fall	8/21/2017–1/15/2018	\$1050.00	\$1,560.00	\$1,158.00	\$1,656.00
Spring	1/16/2018–8/19/2018	\$1050.00	\$1,560.00	\$1,158.00	\$1,656.00
Monthly—Visiting international scholars only	Visiting scholars	\$210.00	\$260.00	\$193.00	\$276.00

If both spouses are both enrolled at the University and are able to satisfy the eligibility requirements for this Student Health Benefit Plan, each may purchase coverage at the student-only cost. Either student may add children who are eligible dependents to their own coverage, but not both.

## Summer Coverage

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

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

Semester	Dates of Coverage	Student	Spouse	Child	Children
Summer	5/14/2018–8/19/2018	\$575.00	\$855.00	\$634.00	\$907.00

## MEDICAL EVACUATION & REPATRIATION BENEFITS

These Benefits are contracted by the Student Health Benefit Plan Administrator with United Health Global. For details, see the enclosed United Health Global brochure, visit the United Health Global website at [www.uhcglobal.com](http://www.uhcglobal.com) or contact. You may also contact the University of Minnesota, Office of Student Health Benefits at 612-624-0627 or e-mail: [umshbo@umn.edu](mailto:umshbo@umn.edu).

**These Benefits are NOT provided by the Claims Administrator, BCBS.**

## ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

These Benefits are contracted by the Student Health Benefit Plan Administrator with Metropolitan Life Insurance Company (MetLife). Contact the University of Minnesota Office of Student Health Benefits at 612-624-0627 or e-mail: [umshbo@umn.edu](mailto:umshbo@umn.edu) for vendor and plan information.

**These Benefits are NOT provided by the Claims Administrator, BCBS**



## DENTAL BENEFITS

Preventative and periodontal dental benefits for primary members (students), and Pediatric dental benefits (up to age 19) are contracted by the Student Health Benefit Plan Administrator with **Delta Dental of Minnesota**. For details, visit the Delta Dental website at [www.deltadentalmn.org/studentdentalplan](http://www.deltadentalmn.org/studentdentalplan) or contact Delta Dental at 800-553-9536. You may also contact the University of Minnesota, Office of Student Health Benefits at 612-624-0627 or e-mail: [umshbo@umn.edu](mailto:umshbo@umn.edu). See pages 47-49 for complete details.

**These Benefits are NOT provided by the Claims Administrator, BCBS.**

# COVERAGE INFORMATION

## *Choosing A Health Care Provider*

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

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

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

### **System Campus Health Service**

Students paying the Student Services Fee (SSF) receive specific SSF benefits when they use the student Health Service at their respective campuses in addition to their SHBP benefits. Covered SHBP students who have not paid the Student Services Fee, and covered SHBP spouses and children may use the UMD Health Service under the In-Network Provider Benefit level.

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

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

### **In-Network Providers**

When you choose In-Network Providers, you get the most benefits for the least expense and paperwork. In-Network Providers have a contract with the Claims Administrator specific to this Plan. In-Network Providers are providers in the Aware Network and the BlueCard Traditional Network. In-Network Providers send your claims to the Claims Administrator and the Claims Administrator sends payment to the provider for covered services you receive. In-Network Providers may take care of prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification requirements for you (refer to the Notification Requirements section).

Your provider directory lists In-Network Providers and may change from time to time, including as providers or the Claims Administrator initiate or terminate network contracts. **Prior to receiving services, it is recommended that you verify your Provider’s network status with the Claims Administrator, including whether the Provider is In-Network for this Plan. Not every provider is In-Network for every plan.** For a list of providers in the directory, visit the Claims Administrator’s website or contact Customer Service. For benefit information, refer to the Benefit Chart.

For current provider information, call customer service at 651-662-5004 or 1-866-870-0348 or you may access the following website: <http://www.bluecrossmnonline.com> and click on the Blue Cross (Aware) icon. For benefit information on these providers, refer to the “Benefit Chart.” For benefit information, refer to the Benefit Chart.

### **Out-of-Network Providers**

#### **Out-of-Network Participating Providers**

Out-of-Network Participating Providers are providers who have a contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan (Participating Providers), but are not In-Network Providers because the contract is not specific to this Plan. Rather, this is the Claims Administrator’s larger open access network.

Out-of-Network Participating Providers may take care of prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification requirements (refer to the Notification Requirements section) and may file claims for you. Verify with your provider if these are services they will provide for you. Most Out-of-Network Participating Providers accept the Claims Administrator's payment based on the allowed amount. The Claims Administrator recommends that you contact the Out-of-Network Participating Provider and verify if they accept the Claims Administrator's payment based on the allowed amount to determine if you will have additional financial liability.

### Nonparticipating Providers

Nonparticipating Providers have not entered into a network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan. You are responsible for providing prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification when necessary, and submitting claims for services received from Nonparticipating Providers. Refer to the Liability for Health Care Expenses provision for a description of charges that are your responsibility. Please note that you may incur significantly higher financial liability when you use Nonparticipating Providers compared to the cost of receiving care from In-Network Providers. If you receive services from a Nonparticipating Provider, you will be responsible for any deductibles or coinsurance plus the DIFFERENCE between what the Claims Administrator would reimburse for the Nonparticipating Provider and the actual charges the Nonparticipating Provider bills. This difference does not apply to your out-of-pocket maximum. This is in addition to any applicable deductible, copay, or coinsurance. Benefit payments are calculated on the Claims Administrator's allowed amount, which is typically lower than the amount billed by the provider. In addition, participating facilities may have nonparticipating professionals practicing at the facility and you may be responsible for significantly higher out-of-pocket expenses for the nonparticipating professional services.

## ***Your Benefits***

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

## ***Continuity of Care***

### **Continuity of Care for New Members**

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

Continuation for up to 120 days if you:

1. have an acute condition;
2. have a life-threatening mental or physical illness;
3. have a physical or mental disability rendering you unable to engage in one or more major life activities provided that the disability has lasted or can be expected to last for at least one year, or that has a terminal outcome;
4. have a disabling or chronic condition in an acute phase or that is expected to last permanently;

5. are receiving culturally appropriate services from a provider with special expertise in delivering those services;  
or
6. are receiving services from a provider that are delivered in a language other than English.

Continuation through the postpartum period (six (6) weeks post delivery) for a pregnancy beyond the first trimester.

### **Transition to In-Network Providers**

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

### **Limitation**

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

Continuity of Care does not apply to services that are not covered under the Plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one plan to another.

### **Provider Termination for Cause**

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

### **Continuity of Care for Current Members**

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

Continuation for up to 120 days if you:

1. have an acute condition;
2. have a life-threatening mental or physical illness;
3. have a physical or mental disability rendering you unable to engage in one or more major life activities provided that the disability has lasted or can be expected to last for at least one year, or that has a terminal outcome;
4. have a disabling or chronic condition in an acute phase or that is expected to last permanently;
5. are receiving culturally appropriate services from a provider with special expertise in delivering those services;  
or
6. are receiving services from a provider that are delivered in a language other than English.

Continuation through the postpartum period (six (6) weeks post delivery) for a pregnancy beyond the first trimester.

## **Transition to In-Network Providers**

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

## **Limitation**

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

Continuity of Care does not apply to services that are not covered under the Plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one plan to another.

## **Provider Termination for Cause**

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

## ***Payments Made in Error***

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

## ***Liability for Health Care Expenses***

### **Charges That Are Your Responsibility**

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

1. charges for services that are not covered.

### **In-Network Providers**

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

1. copays and coinsurance;
2. charges that exceed the benefit maximum; and
3. charges for services that are not covered.

### **Out-of-Network Providers**

#### **Out-of-Network Participating Providers**

When you use Out-of-Network Participating Providers for covered services, payment is still based on the allowed amount. Most Out-of-Network Participating Providers accept the Claims Administrator's payment based on the allowed amount.

However, contact your Out-of-Network Participating Provider to verify if they accept the Claims Administrator's payment based on the allowed amount (to determine if you will have additional financial liability). In addition you are required to pay the following amounts:

1. charges that exceed the allowed amount if the Out-of-Network Participating Provider does not accept the Claims Administrator's payment based on the allowed amount;
2. copays and coinsurance;
3. charges that exceed the benefit maximum; and
4. charges for services that are not covered.

#### Nonparticipating Providers

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

1. charges that exceed the allowed amount;
2. copays and coinsurance;
3. charges that exceed the benefit maximum;
4. charges for services that are not covered; including services that we determine are not covered based on claims coding guidelines.

Your claims may be reprocessed due to errors in the allowed amount paid to In-Network Providers, Out-of-Network Participating Providers, or Nonparticipating Providers. Claim reprocessing may result in changes to the amount you paid at the time your claim was originally processed.

## ***Inter-Plan Programs***

### **Out-of-Area Services**

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

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

### **Inter-Plan Programs Eligibility – Claim Types**

All claim types are eligible to be processed through Inter-Plan Programs, as described above, except for all dental care benefits, (unless paid as medical claims/benefits) and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by the Plan Administrator to provide the specific service or services.

## **BlueCard® Program**

Under the BlueCard® Program, when you access covered health care services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for fulfilling the Claims Administrator's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

Whenever you access covered health care services outside the Claims Administrator's service area and the claim is processed through the BlueCard Program, the amount you pay for covered health care services is calculated based on the lower of:

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

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

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

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

## **Special Cases: Value-Based Programs**

### BlueCard Program

If you receive covered health care services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments. Additional information is available from the Claims Administrator upon request.

## **Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees**

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, the Claims Administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

## **Nonparticipating Providers Outside the Claims Administrator's Service Area**

When covered health care services are provided outside of the Claims Administrator's service area by Nonparticipating Providers the Claims Administrator will pay based on the definition of "Allowed Amount" as set forth in the "Glossary of Common Terms" section of this SPD. In these situations, you may be liable for the difference between the amount that the Nonparticipating Provider bills and the payment the Claims Administrator will make for the covered services as set forth in this paragraph.



## Blue Cross Blue Shield (BCBS) Global Care

### General Information

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the BCBS Global Care when accessing covered health care services. BCBS Global Care is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although BCBS Global Care assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

### Inpatient Services

In most cases, if you contact the BCBS Global Care Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the BCBS Global Care Service Center to initiate claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered health care services.

**You must contact the Claims Administrator to obtain precertification for non-emergency inpatient services.**

### Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered health care services.

### Submitting a BCBS Global Care Claim

When you pay for covered health care services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BCBS Global Care claim form and send the claim form with the provider's itemized bill(s) to the BCBS Global Care Service Center (address on the form) to initiate claims processing. The claim form is available from the Claims Administrator, the BCBS Global Care Service Center, or online at [www.bcbsglobal.com](http://www.bcbsglobal.com). If you need assistance with your claim, submission, you should call the BCBS Global Care Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

## ***General Provider Payment Methods***

### **Participating Providers**

The Claims Administrator contracts with a large majority of doctors, hospitals and clinics in Minnesota to be part of its network. Other Blue Cross and Blue Shield Plans contract with providers in their states as well. (Each Blue Cross and/or Blue Shield Plan is an independent licensee of the Blue Cross and Blue Shield Association.) Each provider is an independent contractor and is not an agent or employee of the Claims Administrator, another Blue Cross and/or Blue Shield Plan, or the Blue Cross and Blue Shield Association. These health care providers are referred to as "Participating Providers." Most Participating Providers have agreed to accept as full payment (less deductibles, coinsurance and copays) an amount that the Claims Administrator has negotiated with its Participating Providers (the "allowed amount").

However, some Participating Providers in a small number of states may not be required to accept the allowed amount as payment in full for your specific plan and will be subject to the Nonparticipating Provider payment calculation noted below.

The Claims Administrator recommends that you verify with your Participating Provider if they accept the allowed amount as payment in full. The allowed amount may vary from one provider to another for the same service.

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

As an incentive to promote high quality, cost effective care and as a way to recognize that those providers participate in certain quality improvement projects, providers may be paid extra amounts following the initial adjudication of a claim based on the quality of the provider’s care to their patients and further based on claims savings that the provider may generate in the course of rendering cost effective care to its member patients. Certain providers also may be paid in advance of a claim adjudication in recognition of their efficiency in managing the total cost of providing high quality care to members and for implementing quality improvement programs. In order to determine quality of care, certain factors are measured to determine a provider’s compliance with recognized quality criteria and quality improvement. Areas of focus for quality may include, but are not limited to: services for diabetes care; tobacco cessation; colorectal cancer screening; and breast cancer screening, among others.

Cost of care is measured using quantifiable criteria to demonstrate that a provider is meeting specific targets to manage claims costs. These quality and cost of care payments to providers are determined on a quarterly or annual basis and will not directly be reflected in a claims payment for services rendered to an individual member. Payments to providers for meeting quality improvement and cost of care goals and for recognizing efficiency are considered claims payments.

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

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

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

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

- **Inpatient Care**

- **Payments for each Case (case rate)** — Providers are paid a fixed amount based upon the member’s diagnosis at the time of admission, regardless of the number of days that the member is hospitalized. This payment amount may be adjusted if the length of stay is unusually long or short in comparison to the average stay for that diagnosis (“outlier payment”). The method is similar to the payment methodology used by the federal government to pay providers for Medicare services.
- **Payments for each Day (per diem)** — Providers are paid a fixed amount for each day the patient spends in the hospital or facility.
- **Percentage of Billed Charges** — Providers are paid a percentage of the hospital’s or facility’s billed charges for inpatient or outpatient services, including home services.

- **Outpatient Care**

- **Payments for each Category of Services** — Providers are paid a fixed or bundled amount for each category of outpatient services a member receives during one (1) or more related visits.
- **Payments for each Visit** — Providers are paid a fixed or bundled amount for all related services a member receives in an outpatient or home setting during one (1) visit.
- **Payments for each Patient** — Providers are paid a fixed amount per patient per plan year for certain categories of outpatient services.

## **Pharmacy Payment**

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

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

## **Nonparticipating Providers**

**When you use a Nonparticipating Provider, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses.** A Nonparticipating Provider does not have any agreement with the Claims Administrator or another Blue Cross and/or Blue Shield Plan. For services received from a Nonparticipating Provider (other than those described under Special Circumstances below), the allowed amount will be based upon one of the following payment options to be determined at the Claims Administrator's discretion: (1) a percentage, not less than 100%, of the Medicare allowed charge for the same or similar service; (2) a percentage of billed charges; (3) pricing determined by another Blue Cross or Blue Shield plan; or (4) pricing based upon a nationwide provider reimbursement database. The payment option selected by the Claims Administrator may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare Allowed Charge is not available, the pricing method is determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the Claims Administrator. The allowed amount for a Nonparticipating Provider is usually less than the allowed amount for a Participating Provider for the same service and can be significantly less than the Nonparticipating Provider's billed charges. You will be paid the benefit under the Plan and **you are responsible for paying the Nonparticipating Provider.** The only exception to this is stated in CLAIMS PROCEDURES, Claims Payment. This amount can be significant and the amount you pay does not apply toward any out-of-pocket maximum contained in the Plan.

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

- **Example of payment for Nonparticipating Providers**

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

The difference in the allowed amount between a Participating Provider and Nonparticipating Provider could be more or less than the 40 percent difference in the following example.

	Participating Provider	Nonparticipating Provider
Provider charge:	\$150	\$150
Allowed amount:	\$100	\$60
Claims Administrator pays:	\$80 (80 percent of the allowed amount)	\$36 (60 percent of the allowed amount)
Coinsurance member owes:	\$20 (20 percent of the allowed amount)	\$24 (40 percent of the allowed amount)
Difference up to billed charge member owes:	None (provider has agreed to write this off)	\$90 (\$150 minus \$60)
Member pays:	\$20	\$114

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

## - Special Circumstances

There may be circumstances where you require medical or surgical care and you do not have the opportunity to select the provider of care, such as hospital-based providers (e.g., anesthesiologists) who may not be Participating Providers. Typically, when you receive care from Nonparticipating Providers, you are responsible for the difference between the allowed amount and the provider's billed charges. However, in circumstances where you needed care, and were not able to choose the provider who rendered such care, the Claims Administrator may pay an additional amount. The extent of reimbursement in certain medical emergency circumstances may also be subject to federal law. Please refer to Emergency Care for benefits.

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

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

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

## Recommendations by Health Care Providers

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

## Services that are Investigative or not Medically Necessary

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

## ***Fraudulent Practices***

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

## ***Time Periods***

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

## ***Medical Policy Committee and Medical Policies***

The Claims Administrator's Medical Policy Committee develops medical policies that determine whether new or existing medical treatment should be covered benefits. The Committee is made up of independent community physicians who represent a variety of medical specialties. The Committee's goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches. The Committee carefully examines the scientific evidence and outcomes for each treatment being considered. From time to time new medical policies may be created or existing medical policies may change. Covered benefits will be determined in accordance with the Claims Administrator's policies in effect at the time treatment is rendered or, if applicable, prior authorization may be required. The Claims Administrator's medical policies may be found at the Claims Administrator's website and are hereby incorporated by reference.

# NOTIFICATION REQUIREMENTS

The Claims Administrator reviews services to verify that they are medically necessary and that the treatment provided is the proper level of care. All applicable terms and conditions of your Student Health Benefit Plan including exclusions, deductibles, copays, and coinsurance provisions continue to apply with an approved prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification.

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

## ***Prior Authorization***

Prior authorization is a process that involves a benefits review and determination of medical necessity before a service is rendered. The Claims Administrator's prior authorization list describes the services for which prior authorization is required. The prior authorization list is subject to change due to changes in the Claims Administrator's medical policy. The Claims Administrator reserves the right to revise, update and/or add to this list at any time without notice. The most current list is available on the Claims Administrator's website or by calling Customer Service.

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

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

**Minnesota Participating Providers who do not obtain prior authorization for you are responsible for the charges if the services are found to be not medically necessary. For claims from a Nonparticipating Provider in Minnesota, or any provider outside Minnesota, if prior authorization is not obtained and if it is found, at the point the claim is processed, that services were not medically necessary, you are liable for all of the charges.**

The Claims Administrator requires that you or the provider contact them at least 10 working days prior to the provider scheduling the care/services to determine if the services are eligible. The Claims Administrator will notify you of their decision within 10 working days, provided that the prior authorization request contains all the information needed to review the service.

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

## ***Preadmission Notification***

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

Minnesota In-Network Providers and Minnesota Out-of-Network Participating Providers are required to provide preadmission notification for you. **If those providers do not provide preadmission notification for you, those providers are responsible for the charges if the admission is found to be not medically necessary.**

If you are going to receive nonemergency inpatient care from a Nonparticipating Provider in Minnesota or any provider outside Minnesota, you are required to provide preadmission notification to the Claims Administrator. Some of these providers may provide preadmission notification for you. Verify with your provider if this is a service they will perform for you or not.

You may also be required to obtain prior authorization for services or procedures while you are an inpatient, e.g., if you are having elective surgery while an inpatient at a Nonparticipating Provider. Refer to Prior Authorization in this section to determine if you, or your provider, are responsible for obtaining any required prior authorization(s).

**Minnesota Participating Providers who do not obtain preadmission notification for you are responsible for the charges, if the admission is found to be not medically necessary. If preadmission notification is not provided and it is found, at the point the claim from a Nonparticipating Provider in Minnesota or any provider outside Minnesota is processed, that services were not medically necessary, you are liable for all of the charges.**

Preadmission notification is required for the following admissions/facilities:

1. Hospital acute care admissions (medical and behavioral); and
2. Residential behavioral health treatment facilities.

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

## ***Preadmission Certification***

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

Minnesota In-Network Providers and Minnesota Out-of-Network Participating Providers are required to provide preadmission certification for you. **If those providers do not provide preadmission certification for you, those providers are responsible for the charges if the admission is found to be not medically necessary.**

If you are going to receive nonemergency inpatient care from a Nonparticipating Provider in Minnesota or any provider outside Minnesota, you are required to provide preadmission certification to the Claims Administrator. Some of these providers may provide preadmission certification for you. Verify with your provider if this is a service they will perform for you or not. **You may also be required to obtain prior authorization for services or procedures while you are an inpatient, e.g., if you are having elective surgery while an inpatient at a Nonparticipating Provider. Refer to Prior Authorization in this section to determine if you, or your provider, are responsible for obtaining any required prior authorization(s). Minnesota Participating Providers who do not obtain preadmission certification for you are responsible for the charges if the admission is found to be not medically necessary. If preadmission certification is not provided and it is found, at the point the claim from a Nonparticipating Provider in Minnesota or any provider outside Minnesota is processed, that services were not medically necessary, you are liable for all of the charges.**

Preadmission certification is required for the following admissions/facilities:

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

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



## ***Emergency Admission Notification***

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

Minnesota In-Network Providers and Minnesota Out-of-Network Participating Providers are required to provide emergency admission notification for you. **If those providers do not provide preadmission for you, those providers are responsible for the charges if the admission is found to be not medically necessary.**

If you receive emergency care from Nonparticipating Providers in Minnesota or any provider outside Minnesota, you are required to provide emergency admission notification to the Claims Administrator within 48 hours of the admission or as soon as reasonably possible following the admission. Some of these providers may provide emergency admission notification for you. Verify with your provider if this is a service they will perform for you or not. **For claims from a Nonparticipating Provider in Minnesota, or any provider outside Minnesota, if emergency admission notification is not provided and it is found, at the point the claim from a Nonparticipating Provider in Minnesota or any provider outside Minnesota is processed, that services were not medically necessary, you are liable for all of the charges.**

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

# CLAIMS PROCEDURES

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

## ***Types of Claims***

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

### **Pre-service Claim**

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

### **Urgent Care Claim**

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

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

### **Concurrent Care Claim**

A “Concurrent Care Claim” arises when the Claims Administrator has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the Claims Administrator determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the Claims Administrator has approved.

If the Student Health Benefit Plan does not require a claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Claims Administrator to request an extension of a course of treatment. The claimant follows these claims procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a Post-service Claim.

## **Post-service Claim**

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

## **Change in Claim Type**

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

## ***Filing Claims***

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

## **Urgent Care Claims**

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

## **Pre-service Claims**

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

## **Post-service Claims**

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

## **Incorrectly-Filed Claims**

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

## ***Timeframes for Deciding Claims***

### **Urgent Care Claims**

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

### **Pre-service Claims**

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

### **Concurrent Care Extension Request**

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

### **Concurrent Care Reduction or Early Termination**

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

### **Post-Service Claims**

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

### **Extensions of Time**

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

## ***Incomplete Claims***

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

The Claims Administrator will decide the claim as soon as possible but no later than 48 hours after the earlier of (a) receipt of the specified information, or (b) the end of the period of time provided to submit the specified information.

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

## ***Notification of Initial Benefit Decision***

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

## ***Appeals of Adverse Benefit Determinations***

### **Appeal Procedures**

If you are covered under a plan offered by a state health plan, a city, county, school district, or Service Cooperative, you may contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789.

A claimant has a right to appeal an adverse benefit determination under these claims procedures. These appeal procedures provide a claimant with a reasonable opportunity for a full and fair review of an adverse benefit determination.

The Claims Administrator will follow these procedures when deciding an appeal:

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

10. The Claims Administrator will provide a claimant any new evidence considered, generated, or relied upon prior to making a final benefit determination;
11. The Claims Administrator will provide a claimant any new rationale for an adverse benefit determination prior to making a final benefit determination; and
12. The Claims Administrator will provide required notices in a culturally and linguistically appropriate manner as directed by the Plan Administrator.

## **Filing Appeals**

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

## **Urgent Care Appeals**

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

## ***Timeframes for Deciding Appeals***

### **Urgent Care Claims**

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

### **Pre-Service Claims**

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

### **Post-service Claims**

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

### **Concurrent Care Claims**

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

## ***Notification of Appeal Decision***

The Claims Administrator will provide the claimant with written notice of the appeal decision. The notification will include the reason for the final adverse benefit determination, reference to the relevant plan provision(s) and other information as required by ERISA. The Claims Administrator may provide the claimant with oral notice of an adverse decision on an Urgent Care Claim appeal, but written notice will be furnished no later than three (3) days after the oral notice. If the claimant does not receive a written response to the appeal within the timeframes described above, the claimant may assume that the appeal has been denied and the claimant may move to the external review process.

Unless these procedures are deemed to be exhausted, the decision by the Claims Administrator on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **These claims procedures must be exhausted before any legal action is commenced.**

Following notification of the appeal decision, a claimant may appeal further to a voluntary internal appeal or to an external appeal (for eligible claims). An adverse benefit determination relating to a claimant's failure to meet eligibility requirements is not eligible for external review.

## ***Voluntary Appeals***

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

## ***External Review***

### **Standard External Review**

You may file a request for an external review within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. The 4 month external review process period begins on the 30<sup>th</sup> calendar day following our receipt of the appeal.

External review applies to claims which involve:

- a. medical judgement in the making of the decision;
  - b. preexisting condition review; or
  - c. coverage rescission determinations.
1. Within five (5) business days following the date of receipt of the external review request, the Claims Administrator will complete a preliminary review of the request to determine whether:
    - a. you are or were covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the plan at the time the health care item or service was provided;
    - b. the adverse benefit determination or the final adverse benefit determination is not based on the fact that you were not eligible under the plan;
    - c. you have exhausted the plan's internal appeal process (unless exhaustion is not required); and
    - d. you have provided all the information and forms required to process an external review. You will be notified if the request is not eligible for external review. If your request is not complete, but eligible, the Claims Administrator will tell you what information or materials are needed to complete the request and will give you 48 hours (or more) to provide the required information.
  2. The Claims Administrator will assign an accredited independent review organization (IRO) to conduct the external review.

The IRO will utilize legal experts where appropriate to make coverage determinations under the plan and will notify you in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within 10 business days that the IRO must consider when conducting the external review.

The Claims Administrator will provide documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO.

The IRO will review all of the information and documents timely received and is not bound by the Claims Administrator's prior determination. The IRO may consider the following in reaching a decision:

- a. your medical records;
- b. the attending health care professional's recommendation;
- c. reports from appropriate health care professionals and other documents submitted by the claims administrator, you, or your treating provider;
- d. the terms of the Plan;
- e. evidence-based practice guidelines;
- f. any applicable clinical review criteria developed and used by the claims administrator; and
- g. the opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

### **Expedited External Review**

1. You may request an expedited external review when you receive:
  - a. an adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
  - b. a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.
2. Immediately upon receipt of the request for expedited external review, the Claims Administrator will determine whether the request meets the reviewability requirements noted above for standard external review and will notify you of its eligibility determination.
3. When the Claims Administrator determines that your request is eligible for external review an IRO will be assigned. The Claims Administrator will provide all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO by any available expeditious method.

The IRO must consider the information or documents provided and is not bound by the Claims Administrator's prior determination.

4. The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO's notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours to the claimant and the plan.



## ***Additional Provisions***

### **Authorized Representative**

A claimant may appoint an “authorized representative” to act on his or her behalf solely with respect to an appeal of an adverse benefit determination or an inquiry concerning an adverse benefit decision. To appoint an authorized representative, a claimant must complete a form that can be obtained from the Claims Administrator.

However, in connection with an Urgent Care Claim, the Claims Administrator will permit a health care professional with knowledge of the claimant's medical condition to act as the claimant's authorized representative without completion of this form. Once an authorized representative is appointed, all future communication from the Claims Administrator will be made with the representative rather than the claimant, unless the claimant provides specific written direction otherwise.

An assignment for purposes of payment (e.g., to a health care professional) does not constitute an appointment of an authorized representative under these claims procedures. Any reference in these claims procedures to claimant is intended to include the authorized representative of such claimant.

A claimant may not assign to any other person or entity his or her right to legally challenge any decision, action, or inaction of the Claims Administrator.

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

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

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

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

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

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

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

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

## **Claims Payment**

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

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

## **No Third Party Beneficiaries**

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

## **Release of Records**

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

## **Right of Examination**

The Claims Administrator and the Plan Administrator each have the right to ask a claimant to be examined by a provider during the review of any claim. The Student Health Benefit Plan pays for the exam whenever either the Claims Administrator or the Plan Administrator requests the exam. A claimant's failure to comply with this request may result in denial of the claimant's claim.

# **INJURIES DURING INTERCOLLEGIATE SPORTS ACTIVITIES**

Benefits for coverage of medical claims for Injuries occurring during the practice or playing of intercollegiate sports under the direction and governance of the University of Minnesota Men's and Women's Intercollegiate Athletic Departments are covered as follows:

- The Student Health Benefit Plan (SHBP) covers a maximum benefit of \$6,000 per injury at 80% coverage of eligible expenses.
- For medical services not covered by the SHBP, Medical coverage for these injuries is fully provided through a combination of University self-insurance and proprietary insurance products. The University covers with a separate blanket accident policy through Berkley Life and Health Insurance Company (BLHIC). The combined benefit through the SHBP and BLHIC covers athletic injury expenses up to \$90,000.
- Medical expenses in excess of \$90,000 are covered through the National Collegiate Athletic Association (NCAA) Catastrophic Insurance Program through Mutual of Omaha Insurance Company.

Intercollegiate athletes do not incur any out of pocket medical costs for injuries resulting from the practice or play of NCAA sanctioned sports.

Please contact the Athletic Department for additional information if required.

## BENEFIT CHART

This section lists covered services and the benefits the Student Health Benefit Plan pays. All benefit payments are based on the allowed amount. Coverage is subject to all other terms and conditions of this Summary Plan Description and must be medically necessary.

### ***Benefit Features, Limitations, and Maximums***

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#### **Networks:**

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Your provider directory lists In-Network Providers in the Claims Administrator's service area and may change from time to time, including as providers or the Claims Administrator initiate or terminate network contracts. Prior to receiving services, it is recommended that you verify your provider's network status with the Claims Administrator, including whether the provider is In-Network for this Plan. Not every provider is In-Network for every plan. For a list of providers in the directory, visit the Claims Administrator's website or contact Customer Service.

- In-Network Providers participating with this Plan      Aware Network Providers and BlueCard Traditional Network Providers

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<b>Benefit Features</b>	<b>Your Liability</b>
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Learn to Live Online Cognitive Behavioral Therapy	No Cost
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#### **Copays**

- Mental Health and Substance Abuse Doctor on Demand office visit copay      \$10 per visit
- E-Visit copay      \$10 per visit
- Retail health clinic copay      \$10 per visit

#### **Prescription Drugs:**

Retail pharmacy:

- FlexRx preferred generic drug copay      \$15 per prescription
- FlexRx preferred brand name drug copay      \$25 per prescription

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<b>Benefit Features</b>	<b>Limitations and Maximums</b>
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#### **Out-of-Pocket Maximums**

- All providers combined      \$6,250 per person per plan year

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

The following items are applied toward the out-of-pocket maximum:

1. coinsurance; and
2. mental health and substance abuse Doctor on Demand copays, E-visit copays, and retail health clinic copays.

The following item is NOT applied toward the out-of-pocket maximum:

1. prescription drug copays.

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**Accidental Injury:** Treatment of accidental injuries resulting from athletes participating in an intercollegiate sports activity

The Student Health Benefit Plan (SHBP) covers a maximum benefit of \$6,000 per injury at 80% coverage of eligible expenses. Refer to Injuries During Intercollegiate Sports Activities on page 36

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### **Lifetime Maximum**

- Total benefit paid to all providers combined                      Unlimited

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### ***Benefit Descriptions***

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

## Ambulance

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>Emergency air or ground transportation licensed to provide basic or advanced life support from the place of departure to the nearest facility equipped to treat the condition</li> <li>Non-emergency medically necessary, prearranged or scheduled air or ground ambulance transportation licensed to provide basic or advanced life support requested by an attending physician or nurse to the nearest (from place of departure) medical facility equipped to treat the condition</li> </ul>	80%	80%

### NOTES:

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

### NOT COVERED:

- services for non-emergency medically necessary prearranged or scheduled air or ground ambulance transportation requested by an attending physician or nurse when you use an Out-of-Network Provider
- ambulance transportation services that are not medically necessary for basic or advanced life support
- transportation services, including ambulance services, that are mainly for your convenience
- ambulance transportation costs that exceed the allowable cost applicable to transport from the place of departure to the nearest medical facility equipped to treat the condition (Example: facility A is the closest medical facility equipped to treat the condition but you choose to be transported to facility B. The Plan will cover eligible medically necessary ambulance transportation costs that would otherwise apply to transportation to facility A. If you choose to be transported by ambulance to facility B, the cost of transportation services in excess of the eligible ambulance transportation costs that would otherwise apply to transportation to facility A are not covered under the Plan, and you will be responsible for those costs.)
- please refer to the General Exclusions section

## Behavioral Health - Mental Health Care

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Doctor on Demand office visits</li> </ul>	100% after you pay the Doctor on Demand copay.	80%, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> <li>• Outpatient health care professional charges for services including:               <ul style="list-style-type: none"> <li>▪ assessment and diagnostic services</li> <li>▪ individual/group/family therapy (office/in-home mental health services)</li> <li>▪ neuro-psychological examinations</li> <li>▪ telemedicine services</li> </ul> </li> <li>• Professional health care charges for services including:               <ul style="list-style-type: none"> <li>▪ clinical based partial programs</li> <li>▪ clinical based day treatment</li> <li>▪ clinical based Intensive Outpatient Programs (IOP)</li> </ul> </li> <li>• Outpatient hospital/outpatient behavioral health treatment facility charges for services including:               <ul style="list-style-type: none"> <li>▪ evaluation and diagnostic services</li> <li>▪ individual/group therapy</li> <li>▪ crisis evaluations</li> <li>▪ observation beds</li> <li>▪ family therapy</li> <li>▪ telemedicine services</li> </ul> </li> <li>• Inpatient health care professional charges</li> <li>• Inpatient hospital and inpatient residential behavioral health treatment facility charges for services including:               <ul style="list-style-type: none"> <li>▪ hospital based partial programs</li> <li>▪ hospital based day treatment</li> <li>▪ hospital based Intensive Outpatient Programs (IOP)</li> <li>▪ all eligible inpatient services</li> <li>▪ emergency holds</li> <li>▪ telemedicine services</li> </ul> </li> </ul>	80%	80%, plus you pay any charges billed to you that exceed the allowed amount.

### NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a physician or a licensed psychologist is deemed medically necessary.

- Court-ordered treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity. Court-ordered treatment that does not meet the criteria above will be covered if it is determined to be medically necessary and otherwise covered under this Student Health Benefit Plan.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
- Admissions that qualify as “emergency holds” as the term is defined in Minnesota statutes are considered medically necessary for the entire hold.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, physician time, or psychotherapy.
- Coverage provided for treatment of emotionally disabled children in a licensed residential behavioral health treatment facility is covered the same as any other inpatient hospital medical admission.
- For home health related services, refer to Home Health Care.
- Psychoeducation is covered for individuals diagnosed with schizophrenia, bipolar disorder, and borderline personality disorder. Psychoeducational programs are delivered by an eligible provider to the patient on a group or individual basis as part of a comprehensive treatment program. Patients receive support, information, and management strategies specifically related to their diagnosis.
- Coverage is provided for crisis evaluations delivered by mobile crisis units.
- Telemedicine services may also be referred to as televideo consultations or telehealth services. These services are interactive audio and video communications, permitting real-time communication between a distant site physician or practitioner and the member, who is present and participating in the televideo visit at a remote facility.

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#### **NOT COVERED:**

- treatment of attention deficit disorder with or without mention or presence of hyperactivity disorder (testing and evaluation is covered)
  - services for mental illness not listed in the most recent editions of the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM)
  - custodial care, nonskilled care, adult daycare or personal care attendants
  - services or confinements ordered by a court or law enforcement officer that are not medically necessary; services that are not considered medically necessary include, but are not limited to the following: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; parental competency; and domestic violence programs
  - room and board for foster care, group homes, incarceration, shelter care, and lodging programs
  - halfway house services
  - services for marital/couples counseling
  - services for or related to marital/couples training for the primary purpose of relationship enhancement including, but not limited to premarital education; or marriage/couples retreats, encounters, or seminars
  - educational services with the exception of nutritional education for individuals diagnosed with anorexia nervosa, bulimia, or eating disorders NOS (not otherwise specified)
  - skills training
  - therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child’s improved functioning)
  - services for or related to intensive behavioral therapy programs for the treatment of autism spectrum disorders including, but not limited to: Intensive Early Intervention Behavioral Therapy Services (IEIBTS); Intensive Behavioral Intervention (IBI); and Lovaas Therapy
  - services for the treatment of learning disabilities
  - therapeutic day care and therapeutic camp services
  - hippotherapy (equine movement therapy)
  - services provided during telemedicine services for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite visit; and services that would similarly not be charged for in an onsite visit
  - facsimile transmission communications between members and providers
  - please refer to the General Exclusions section
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## Behavioral Health - Substance Abuse Care

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>Doctor on Demand office visits</li> </ul>	100% after you pay the Doctor on Demand copay.	80%, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> <li>Outpatient health care professional charges for services including:                             <ul style="list-style-type: none"> <li>assessment and diagnostic services</li> <li>family therapy</li> <li>opioid treatment</li> <li>telemedicine services</li> </ul> </li> <li>Outpatient hospital/outpatient behavioral health treatment facility charges for services including Intensive Outpatient Programs (IOP), telemedicine services, and related aftercare services</li> <li>Inpatient health care professional charges</li> <li>Inpatient hospital/residential behavioral health treatment facility charges</li> </ul>	80%	80%, plus you pay any charges billed to you that exceed the allowed amount.

### NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Admissions that qualify as “emergency holds,” as the term is defined in Minnesota statutes, are considered medically necessary for the entire hold.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, physician time, or psychotherapy.
- Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for treatment of a behavioral health diagnosis.
- For home health related services, refer to Home Health Care.
- Telemedicine services may also be referred to as televideo consultations or telehealth services. These services are interactive audio and video communications, permitting real-time communication between a distant site physician or practitioner and the member, who is present and participating in the televideo visit at a remote facility.

### NOT COVERED:

- treatment of attention deficit disorder with or without mention or presence of hyperactivity disorder (testing and evaluation is covered)
- services for substance abuse or addictions not listed in the most recent editions of the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM)

- custodial care, nonskilled care, adult daycare or personal care attendants
  - services or confinements ordered by a court or law enforcement officer that are not medically necessary; services that are not considered medically necessary include, but are not limited to the following: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; parental competency; and domestic violence programs
  - room and board for foster care, group homes, incarceration, shelter care, and lodging programs
  - halfway house services
  - substance abuse interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person with the intent of convincing the affected person to enter treatment for the condition
  - services provided during telemedicine services for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite visit; and services that would similarly not be charged for in an onsite visit
  - facsimile transmission communications between members and providers
  - please refer to the General Exclusions section
-

## Chiropractic Care

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>Office visits from a Doctor of Chiropractic</li> <li>Manipulations</li> <li>Therapies</li> <li>Other chiropractic services</li> </ul>	80%	80%, plus you pay any charges billed to you that exceed the allowed amount.

### NOTES:

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

### NOT COVERED:

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

## Dental Care administered by BCBS

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<p><b>This is not a dental plan. The following limited dental-related coverage is provided:</b></p> <ul style="list-style-type: none"> <li>• Accident-related dental services from a physician or dentist for the treatment of an injury to sound and healthy natural teeth</li> <li>• Treatment of cleft lip and palate when services are scheduled or initiated including: <ul style="list-style-type: none"> <li>▪ dental implants</li> <li>▪ removal of impacted teeth or tooth extractions</li> <li>▪ related orthodontia</li> <li>▪ related oral surgery</li> <li>▪ bone grafts</li> </ul> </li> <li>• Surgical and nonsurgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder including: <ul style="list-style-type: none"> <li>▪ orthognathic surgery</li> <li>▪ related orthodontia</li> </ul> </li> </ul>	80%	80%, plus you pay any charges billed to you that exceed the allowed amount.

### NOTES:

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

- Bone grafts for the purpose of reconstruction of the jaw and for treatment of cleft lip and palate is a covered service, but not for the sole purpose of supporting a dental implant, dentures or a dental prosthesis.
- A sound and healthy natural tooth is a viable tooth (including natural supporting structures) that is free from disease that would prevent continual function of the tooth for at least one year. In the case of primary (baby) teeth, the tooth must have a life expectancy of one year. A dental implant is not a sound and healthy natural tooth.

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**NOT COVERED:**

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

### University of Minnesota – Preventive/Periodontics Plan

Plan Benefit Highlights	
Network(s)	Preventive/Periodontics Plan
<b>Plan Year Maximum (9/1/17 – 8/31/18)</b> Per person	N/A
<b>Deductible (9/1/17 – 8/31/18)</b> Per person per plan year <i>*No deductible for diagnostic and preventive services and non-surgical periodontics</i>	N/A
Covered Services	Dental Benefit Plan Coverage
<b>Diagnostic &amp; Preventive Services</b> Exams Cleanings X-rays Sealants	100%
<b>Periodontics</b> Nonsurgical procedures	80%

This is a summary of benefits only and does not guarantee coverage. For a complete list of covered services and limitations/exclusions, please refer to the Dental Benefit Plan Summary.

\*Dentists who have signed a participating network agreement with Delta Dental have agreed to accept the maximum allowable fee as payment in full. Non-participating dentists have not signed an agreement and are not obligated to limit the amount they charge; the member is responsible for paying any different to the non-participating dentists.

## Pediatric Dental Administered by Delta Dental

### University of Minnesota – Pediatric Dental Plan

Plan Benefit Highlights			
Network(s)	Delta Dental PPO	Delta Dental Premier	Non-Participating
<b>Plan Year Maximum (9/1/17 – 8/31/18)</b> Per person	N/A	N/A	\$1,000
<b>Orthodontic Maximum</b> Dentally necessary Orthodontic Care (dependent child only)	N/A	N/A	N/A
<b>Deductible (9/1/17 – 8/31/18)</b> Per person per plan year <i>*No deductible for diagnostic and preventive services and non-surgical periodontics</i>	\$0/person	\$0/person	\$0/person
<b>Eligible Dependents</b>	Students and dependent children up to age 19		
Covered Services	Dental Benefit Plan Coverage		
<b>Diagnostic &amp; Preventive Services</b> Exams Cleanings X-rays Fluoride treatments Sealants Space maintainers	100%	100%	100%
<b>Periodontics</b> Surgical/Nonsurgical periodontics	100%	100%	100%
<b>Basic Services</b> Emergency treatment for relief of pain Amalgam restorations (silver fillings) Composite resin restorations (white fillings) on anterior (front) teeth Composite resin restorations (white fillings) on posterior (back) teeth will be paid at the amalgam allowance	80%	80%	80%

<b>Endodontics</b> Root canal therapy on permanent teeth Pulpotomies on primary teeth for dependent children	80%	80%	80%
<b>Oral Surgery</b> Surgical/Nonsurgical extractions All other covered oral surgery	80%	80%	80%
<b>Major Restorative</b> Crowns and crown repair	50%	50%	50%
<b>Prosthetic Repairs and Adjustments</b> Denture adjustments and repairs Bridge repair	50%	50%	50%
<b>Prosthetics</b> Dentures (full and partial) Bridges	50%	50%	50%
<b>Orthodontics</b> ***Dentally necessary Orthodontic Care (dependent children only)	50%***	50%***	50%***

This is a summary of benefits only and does not guarantee coverage. For a complete list of covered services and limitations/exclusions, please refer to the Dental Benefit Plan Summary.

\*Dentists who have signed a participating network agreement with Delta Dental have agreed to accept the maximum allowable fee as payment in full. Non-participating dentists have not signed an agreement and are not obligated to limit the amount they charge; the member is responsible for paying any different to the non-participating dentists.



## Emergency Room

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"><li>• Outpatient hospital/facility emergency room charges</li><li>• Outpatient health care professional charges</li></ul>	80%	80%

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### NOTES:

- **Refer to Emergency Admission Notification on page 26.**
- When determining if a situation is a medical emergency, the Claims Administrator will take into consideration a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day.
- For inpatient services, refer to Hospital Inpatient and Physician Services.
- For urgent care visits, refer to Hospital Outpatient and Physician Services.
- For take-home prescription drugs, refer to Prescription Drugs and Insulin.

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### NOT COVERED:

- please refer to the General Exclusions section
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## Home Health Care

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Skilled care and other home care services ordered by a physician and provided by employees of a Medicare approved or other preapproved home health agency including, but not limited to: <ul style="list-style-type: none"> <li>▪ intermittent skilled nursing care in your home by a: <ul style="list-style-type: none"> <li>- licensed registered nurse</li> <li>- licensed practical nurse</li> </ul> </li> <li>▪ services provided by a medical technologist</li> <li>▪ services provided by a licensed dietician</li> <li>▪ services provided by a respiratory therapist</li> <li>▪ physical and occupational therapy by a licensed therapist and speech therapy by a certified speech and language pathologist</li> <li>▪ services of a home health aide or masters level social worker employed by the home health agency when provided in conjunction with services provided by the above listed agency employees</li> <li>▪ use of appliances that are owned or rented by the home health agency</li> <li>▪ home health care following early maternity discharge</li> <li>▪ palliative care</li> </ul> </li> </ul>	80%	80%, plus you pay any charges billed to you that exceed the allowed amount.

### NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Benefits for home infusion therapy and related home health care are listed under Home Infusion Therapy.
- For prescription drugs, refer to Prescription Drugs and Insulin.
- For supplies and durable medical equipment billed by a Home Health Agency, refer to Medical Equipment, Prosthetics, and Supplies.

- The Student Health Benefit Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.

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**NOT COVERED:**

- services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care - refer to Skilled nursing care - extended hours, Skilled nursing care - intermittent hours, and Skilled care in the Glossary of Common Terms section
  - charges for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury
  - treatment, services or supplies which are not medically necessary
  - please refer to the General Exclusions section
-

## Home Infusion Therapy

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Home infusion therapy services when ordered by a physician</li> <li>• Solutions and pharmaceutical additives and dispensing services</li> <li>• Durable medical equipment</li> <li>• Ancillary medical supplies</li> <li>• Nursing services to: <ul style="list-style-type: none"> <li>▪ train you or your caregiver</li> <li>▪ monitor your home infusion therapy</li> </ul> </li> <li>• Collection, analysis, and reporting of lab tests to monitor response to home infusion therapy</li> <li>• Other eligible home health services and supplies provided during the course of home infusion therapy</li> </ul>	80%	80%, plus you pay any charges billed to you that exceed the allowed amount.

### NOTE:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.

### NOT COVERED:

- home infusion services or supplies not specifically listed as covered services
- nursing services to administer therapy that you or another caregiver can be successfully trained to administer
- services that do not involve direct patient contact, such as delivery charges and recordkeeping
- investigative or non-FDA approved drugs, except as required by law
- please refer to the General Exclusions section

## Hospice Care

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>Hospice care for a terminal condition provided by a Medicare approved hospice provider or other preapproved hospice including: <ul style="list-style-type: none"> <li>routine home care</li> <li>continuous home care</li> <li>inpatient respite care</li> <li>general inpatient care</li> </ul> </li> </ul>	80%	80%, plus you pay any charges billed to you that exceed the allowed amount.

### NOTES:

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

### NOT COVERED:

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

## Hospital Inpatient

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>Room and board and general nursing care</li> <li>Intensive care and other special care units</li> <li>Operating, recovery, and treatment rooms</li> <li>Anesthesia</li> <li>Prescription drugs and supplies used during a covered hospital stay</li> <li>Lab and diagnostic imaging</li> <li>Telemedicine services</li> <li>Communication services of a private duty nurse or a personal care assistant up to 120 hours during a hospital admission</li> </ul>	80%	80%, plus you pay any charges billed to you that exceed the allowed amount.

### NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- The Plan covers kidney and cornea transplants. For kidney transplants performed in conjunction with an eligible major transplant or other kinds of transplants, refer to Transplant Coverage.
- The Plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the Plan:
  - potential donor testing
  - donor evaluation and work-up; and
  - hospital and professional services related to organ procurement
- The Student Health Benefit Plan covers anesthesia and inpatient and outpatient hospital charges when necessary to provide dental care to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.
- For take-home prescription drugs, refer to Prescription Drugs and Insulin.
- Telemedicine services may also be referred to as televideo consultations or telehealth services. These services are interactive audio and video communications, permitting real-time communication between a distant site physician or practitioner and the member, who is present and participating in the televideo visit at a remote facility.

### NOT COVERED:

- services for or related to bariatric surgery
- communication services provided on an outpatient basis or in the home
- services provided during telemedicine services for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite visit; and services that would similarly not be charged for in an onsite visit
- facsimile transmission communications between members and providers
- travel expenses for a kidney donor

- kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
  - kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
  - services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care - refer to Skilled nursing care - extended hours, Skilled nursing care - intermittent hours, and Skilled care in the Glossary of Common Terms section
  - please refer to the General Exclusions section
-

## Hospital Outpatient

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>Scheduled surgery/anesthesia</li> <li>Radiation and chemotherapy</li> <li>Kidney dialysis</li> <li>Respiratory therapy</li> <li>Physical, occupational, and speech therapy</li> <li>Lab and diagnostic imaging</li> <li>Diabetes outpatient self-management training and education, including medical nutrition therapy</li> <li>Palliative care</li> <li>Telemedicine services</li> <li>Facility urgent care services</li> <li>All other outpatient hospital care</li> </ul>	80%	80%, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> <li>Rabies vaccine</li> </ul>	100%	80%, plus you pay any charges billed to you that exceed the allowed amount.

### NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- The following services are covered at the In-Network level of benefits (applying to the In-Network deductible and out-of-pocket maximum, if applicable) from providers who are not affiliated with the Claims Administrator. These services may be covered under Hospital Outpatient, Physician Services, or Preventive Care based on the nature of the service(s) provided.
  - voluntary planning of the conception and bearing of children;
  - diagnosis of infertility;
  - testing and treatment of a sexually transmitted disease; and
  - testing of AIDS or other HIV-related conditions.
- The Student Health Benefit Plan covers anesthesia and inpatient and outpatient hospital charges when necessary to provide dental care to a covered person who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.
- The Student Health Benefit Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- Telemedicine services may also be referred to as televideo consultations or telehealth services. These services are interactive audio and video communications, permitting real-time communication between a distant site physician or practitioner and the member, who is present and participating in the televideo visit at a remote facility.
- For take-home prescription drugs, refer to Prescription Drugs and Insulin.



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**NOT COVERED:**

- services for or related to bariatric surgery
  - services provided during telemedicine services for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite visit; and services that would similarly not be charged for in an onsite visit
  - facsimile transmission communications between members and providers
  - please refer to the General Exclusions section
-

## Maternity

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>Health care professional services for: <ul style="list-style-type: none"> <li>delivery</li> <li>postpartum care</li> </ul> </li> <li>Inpatient and outpatient hospital/facility services for: <ul style="list-style-type: none"> <li>delivery</li> <li>postpartum care</li> </ul> </li> </ul>	80%	80%, plus you pay any charges billed to you that exceed the allowed amount.

### NOTES:

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

### NOT COVERED:

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

## Pediatric Vision

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>Medically necessary corrective lenses for children up to the age of 19 as follows:               <ul style="list-style-type: none"> <li>eyeglasses (lenses and frames); maximum of one (1) standard frame and one (1) pair of lenses per person per calendar year (see NOTES below); or</li> <li>contact lenses; maximum of one (1) pair of contact lenses or one (1) year supply of disposable contact lenses per person per calendar year; and</li> <li>eligible low vision aids prescribed by eligible Ophthalmologists or Optometrists specializing in low vision care</li> </ul> </li> </ul>	100%	<b>NO COVERAGE.</b>

### NOTES:

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- Lenses include: single, bifocal, trifocal, lenticular lens powers, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, and polycarbonate prescription lenses with scratch resistance coating.
- Participating Providers maintain a "collection" of standard frames to choose from for corrective lenses for children up to the age of 19. Premium frames that are outside the "standard collection" are not covered.

### NOT COVERED:

- corrective lenses (including frames) for children up to the age of 19 from an Out-of-Network Provider
- premium frames for corrective lenses for children up to the age of 19 that are outside the "standard collection"
- services for or related to lenses, frames, contact lenses, or other fabricated optical devices or professional services to fit or supply them, including the treatment of refractive errors such as radial keratotomy, except as specified in the Benefit Chart
- please refer to the General Exclusions section

## Medical Equipment, Prosthetics, and Supplies

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>Durable medical equipment (DME), including wheelchairs, ventilators, oxygen, oxygen equipment, and hospital beds</li> <li>Devices for habilitative and rehabilitative services</li> <li>Medical supplies, including splints, nebulizers, surgical stockings, casts, and dressings</li> <li>Insulin pumps, glucometers and related equipment and devices</li> <li>Blood, blood plasma, and blood clotting factors</li> <li>Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes</li> <li>Special dietary treatment for Phenylketonuria (PKU) when recommended by a physician</li> <li>Corrective lenses for aphakia</li> <li>Hearing aids</li> <li>Custom foot orthoses only if you have a diagnosis of diabetes with neurological manifestations of one (1) or both feet</li> </ul>	80%	80%, plus you pay any charges billed to you that exceed the allowed amount.

### NOTES:

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

### NOT COVERED:

- solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the Benefit Chart
- personal and convenience items or items provided at levels which exceed the Claims Administrator's determination of medically necessary

- services or supplies that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment; air purifiers; air conditioners; dehumidifiers; heat/cold appliances; water purifiers; hypoallergenic mattresses; waterbeds; computers and related equipment; car seats; feeding chairs; pillows; food or weight scales; hot tubs; whirlpools; and incontinence pads or pants
  - modifications to home, vehicle, and/or workplace, including vehicle lifts and ramps
  - blood pressure monitoring devices
  - phototherapy devices and/or bulbs for seasonal affective disorder (SAD)
  - communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate
  - services for or related to lenses, frames, contact lenses, or other fabricated optical devices or professional services to fit or supply them, including the treatment of refractive errors such as radial keratotomy, except as specified in the Benefit Chart
  - duplicate equipment, prosthetics, or supplies
  - replacement of properly functioning durable medical equipment
  - foot orthoses, except as provided in the Benefit Chart
  - scalp/cranial hair prostheses (wigs)
  - non-prescription supplies such as alcohol, cotton balls and alcohol swabs
  - electric or hospital grade breast pump
  - devices for maintenance services
  - please refer to the General Exclusions section
-

## Physical Therapy, Occupational Therapy, Speech Therapy

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>Habilitative and rehabilitative office visits from a physical therapist, occupational therapist, speech or language pathologist</li> <li>Therapies</li> </ul>	80%	80%, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> <li>Office visits from a physician</li> </ul>	For the level of coverage, refer to Physician Services.	For the level of coverage, refer to Physician Services.

### NOTES:

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

### NOT COVERED:

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

## Physician Services

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Office visits <ul style="list-style-type: none"> <li>▪ illness</li> <li>▪ urgent care</li> </ul> </li> <li>• Telemedicine services</li> <li>• Allergy testing, serum, and injections</li> <li>• Diabetes outpatient self-management training and education, including medical nutrition therapy</li> <li>• Lab and diagnostic imaging</li> <li>• Inpatient hospital/facility visits during a covered admission</li> <li>• Outpatient hospital/facility visits</li> <li>• Anesthesia by a provider other than the operating, delivering, or assisting provider</li> <li>• Surgery, including circumcision and sterilization (see NOTES)</li> <li>• Assistant surgeon</li> <li>• Injectable drugs administered by a health care professional</li> <li>• Palliative care</li> </ul>	80%	80%, plus you pay any charges billed to you that exceed the allowed amount.
<ul style="list-style-type: none"> <li>• Retail health clinic services including, but not limited to office visits and lab services</li> </ul>	100% after you pay the retail health clinic copay.	100% after you pay the retail health clinic copay, plus you pay any charges billed to you that exceed the allowed amount.

• E-visit	100% after you pay the E-visit copay.	80%, plus you pay any charges billed to you that exceed the allowed amount.
• Rabies vaccine	100%	80%, plus you pay any charges billed to you that exceed the allowed amount.

**NOTES:**

- Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Refer to the Notification Requirements section.
- If more than one (1) surgical procedure is performed during the same operative session, the Student Health Benefit Plan covers the surgical procedures based on the allowed amount for each procedure. The Student Health Benefit Plan does not cover a charge separate from the surgery for pre-operative and post-operative care.
- The Student Health Benefit Plan covers treatment of diagnosed Lyme disease on the same basis as any other illness.
- The following services are covered at the In-Network level of benefits (applying to the In-Network deductible and out-of-pocket maximum, if applicable), and you are not responsible for charges that exceed the allowed amount from providers who are not affiliated with the Claims Administrator. These services may be covered under Hospital Outpatient, Physician Services, or Preventive Care based on the nature of the service(s) provided:
  - voluntary planning of the conception and bearing of children;
  - diagnosis of infertility;
  - testing and treatment of a sexually transmitted disease; and
  - testing of AIDS or other HIV-related conditions.
- The Student Health Benefit Plan covers certain physician services for preventive care. Refer to Preventive Care.
- Specific surgical implants and tubal ligation for elective female sterilization are covered under preventive care. Refer to Preventive Care.
- For kidney transplants performed in conjunction with an eligible major transplant, refer to Transplant Coverage.
- For members diagnosed with end stage renal disease (ESRD), your provider is required to complete the Centers for Medicare & Medicaid Services (CMS) form 2728 ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. Your provider must send the completed form to CMS and the Claims Administrator. Please verify with your provider that form 2728 has been completed and submitted.
- The Plan covers certain patient costs for approved clinical trials. Routine patient costs include items and services that would be covered for members who are not enrolled in an approved clinical trial.
- Office visits may include medical history, medical examination, medical decision making, testing, counseling, coordination of care, nature of presenting problem, and the physician's time.
- An E-Visit is a patient initiated, limited on-line evaluation and management health care service provided by a physician or other qualified health care provider using the internet or similar secure communications network to communicate with an established patient.
- A retail health clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail health clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the retail health clinic. Access to retail health clinic services is available on a walk-in basis.
- The Student Health Benefit Plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.
- Telemedicine services may also be referred to as televideo consultations or telehealth services. These services are interactive audio and video communications, permitting real-time communication between a distant site physician or practitioner and the member, who is present and participating in the televideo visit at a remote facility.
- The Plan covers hearing aid exams/fittings/adjustments.



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**NOT COVERED:**

- services for or related to bariatric surgery
  - repair of scars and blemishes on skin surfaces
  - services and prescription drugs for or related to reproduction treatment including assisted reproductive technology (ART), artificial insemination (AI), and intrauterine insemination (IUI) procedures.
  - separate charges for pre-operative and post-operative care for surgery
  - internet or similar network communications for the purpose of: scheduling medical appointments; refilling or renewing existing prescription medications; reporting normal medical test results; providing education materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for an onsite medical office visit, except as specified in the Benefit Chart
  - provider initiated email communications
  - cosmetic surgery to repair a physical defect
  - travel expenses for a kidney donor
  - kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan
  - kidney donor expenses when the recipient is not covered for the kidney transplant under this Plan
  - services and supplies for professional and facility sexual dysfunction or inadequacy procedures
  - please refer to the General Exclusions section
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## Prescription Drugs and Insulin

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>▪ Prescription drugs</li> <li>▪ insulin</li> <li>▪ prescribed drug therapy supplies including, but not limited to: blood/urine testing tabs/strips; needles and syringes; and lancets</li> <li>▪ prescription injectable drugs that are self-administered and do not require the services of a health care professional</li> <li>▪ tobacco cessation drugs and products, including over-the-counter tobacco cessation products</li> <li>▪ oral, transdermal, injectable, intravaginal, and barrier contraceptives for women of reproductive capacity, not otherwise described below</li> <li>▪ amino acid-based elemental formula</li> <li>▪ prescription prenatal vitamins</li> <li>▪ prescription pediatric multivitamins with fluoride</li> <li>▪ cosmetic alteration medications for or related to the treatment of gender identity disorder</li> </ul>	<p>100% after you pay the applicable member cost-sharing when you present your ID card or otherwise provide notice of coverage at the time of purchase. Refer to Prescription Drugs in the Benefit Chart.</p>	<p>100% after you pay the applicable member cost-sharing, plus you pay any charges billed to you that exceed the allowed amount. You must pay the full amount of the prescription at the time of purchase and submit the claim for reimbursement yourself. Refer to Prescription Drugs in the Benefit Chart.</p>
<ul style="list-style-type: none"> <li>• Benefits are provided for the full range of FDA-approved preventive contraceptive methods and for patient education/counseling for women with reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers of Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply.</li> <li>• Specific emergency contraceptives</li> <li>• Benefits are provided for designated preventive drugs with a prescription (such as tobacco cessation drugs and products, aspirin, folic acid, vitamin D, iron, and fluoride supplements) which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers of Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply.</li> </ul> <p>For more information regarding contraceptive or preventive prescription drug coverage, visit the Claims Administrator's website.</p>	<p>100%</p>	<p>80% plus you pay any charges billed to you that exceed the allowed amount. You must pay the full amount of the prescription at the time of purchase and submit the claim for reimbursement yourself.</p>

<ul style="list-style-type: none"> <li>Designated over-the-counter (OTC) drugs with a prescription</li> </ul>	100% when you present your ID card or otherwise provide notice of coverage at the time of purchase.	<b>NO COVERAGE.</b>
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#### NOTES:

- Prior authorization is required for certain prescription drugs. Refer to the Notification Requirements section. For a list of prescription drugs requiring prior authorization visit the Claims Administrator's website.
- For information regarding contraceptive coverage, please visit the Claims Administrator's website or contact Customer Service.
- Coverage is provided only for prescription drugs, insulin and drug therapy supplies listed on the FlexRx preferred drug list and eligible OTC drugs. For a list of drugs on your specified preferred drug list, visit the Claims Administrator's website or contact Customer Service.
- The Claims Administrator applies medical management in determining which contraceptives are included on your specified preferred drug list, as well as a subset of contraceptive medications where a \$0 member liability cost-sharing applies. To view a current list of contraceptive medications that are eligible for coverage without member cost-sharing under your plan visit the Claims Administrator's website or call Customer Service. If your prescribing health care professional determines that none of the \$0 member cost-sharing options available under your plan are clinically appropriate for you, he or she may request an exception through the Claims Administrator's website. If the exception request is approved, the contraceptive medications are eligible for \$0 member cost-sharing.
- You must present your ID card or otherwise provide notice of coverage at the time of purchase to receive the highest level of benefits. If you do not present your ID card or otherwise provide notice of coverage at the time of purchase, the pharmacy will charge you the full amount of the prescription drug. You will be reimbursed based on the discounted pricing. Therefore, in addition to any applicable member cost-sharing, you will also be liable for the difference between the amount the pharmacy charges you for the prescription drug at the time of purchase and any discounted pricing the Claims Administrator has negotiated with participating pharmacies for that prescription drug.
- The following ADHD medications are eligible with no quantity limitations; mixed amphetamine salts (generic Adderall XR only) - immediate and extended release; methylphenidate HCL 5mg, 10mg, 20mg and methylphenidate HCL 10 mg and 20 mg ER; dextroamphetamine 5mg, 10mg (Dexedrine generic only); Strattera and Amphetamine/Dextroamphetamine 5mg and 10 mg (manufactured by Mallinckrodt).
- Prescription drugs and diabetic supplies are generally covered in a 30-day supply from a retail pharmacy. Some medications may be subject to a quantity limitation per days supply or to a maximum dosage per day.
- Up to 3-cycle supply of self-administered oral contraceptives may be purchased at a retail pharmacy at one time for one (1) copay, or for one copay per cycle.
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- Designated Over-the-Counter (OTC) drugs are generally covered up to a 31-day supply, as an alternative for similar prescription medications, subject to package limitations, at a retail participating pharmacy. .
- If your physician has indicated that a non-preferred drug be Dispense as Written (DAW), you will only be charged the preferred drug copay. This provision does not apply to preventive contraception coverage included in the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA). The health care professional must submit a written exception request to the Claims Administrator. This request must indicate that the preferred drug(s) cause an adverse reaction or is contraindicated for the patient or demonstrate that the non-preferred drug be DAW to provide maximum benefit to the patient.
- The Plan covers prescription tobacco cessation drugs and products and over-the-counter (OTC) tobacco cessation drugs and products with a physician's prescription subject to your applicable member cost-sharing. Participants in Stop-Smoking Support may use documented enrollment in place of a physician's prescription for OTC tobacco cessation drugs and products. Some quantity limitation may apply.
- The Plan will cover off label drugs used for cancer treatment as specified by law.
- When identical chemical entities including OTC drugs and similar prescription alternatives, are from different manufacturers or distributors, the Claims Administrator's Coverage Committee may determine that only one of those drug products is covered and the other equivalent products are not covered.

- To locate a participating pharmacy in your area, call the pharmacy information telephone number provided in the Customer Service section.
- For prescription drugs dispensed and used during a covered hospital stay, refer to Hospital Inpatient.
- For supplies or appliances, except as provided in this Benefit Chart, refer to Medical Equipment, Prosthetics and Supplies.
- When you pay for your prescription drugs, insulin and drug therapy supplies yourself, you are required to submit the drug receipt(s) with the claim form for reimbursement.
- The Plan Administrator and/or the Claims Administrator may receive pharmaceutical manufacturer volume discounts in connection with the purchase of certain prescription drugs covered under the Plan. Such discounts are the sole property of the Plan Administrator and/or Claims Administrator and will not be considered in calculating any coinsurance, copay, or benefit maximums.

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**NOT COVERED:**

- charges for giving injections that can be self-administered
  - over-the-counter drugs, except as specified in the Benefit Chart
  - investigative or non-FDA approved drugs, except as required by law
  - vitamin or dietary supplements, except as specified in the Benefit Chart
  - 
  - prescription drugs for or related to assisted reproductive technology (ART)
  - medication for treatment of sexual dysfunction, including, but not limited to erectile dysfunction
  - non-prescription supplies such as alcohol, cotton balls and alcohol swabs
  - selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety or side effects
  - weight loss medications
  - non-preferred drugs
  - cosmetic alteration medications, except as specified in the Benefit Chart
  - 90dayRx drugs
  - please refer to the General Exclusions section
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## Preventive Care

The Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Preventive care services provided by health care professionals, outpatient hospitals/facilities, and medical equipment suppliers including: <ul style="list-style-type: none"> <li>▪ age and gender appropriate periodic health examinations and screenings: <ul style="list-style-type: none"> <li>- abdominal aortic aneurysm (AAA)</li> <li>- diabetes</li> <li>- hearing screening</li> <li>- hemoglobin – CBC</li> <li>- hemoglobin – A1C</li> <li>- immunizations</li> <li>- infant and child screenings</li> <li>- lipid profile including total cholesterol and HDL cholesterol</li> <li>- obesity</li> <li>- osteoporosis</li> <li>- screening for lung cancer</li> <li>- screening for sexually transmitted disease and infection (including HIV and HPV)</li> <li>- thyroid</li> <li>- tobacco and alcohol use</li> <li>- urinalysis</li> <li>- vision exam (glaucoma, acuity, and refraction)</li> </ul> </li> <li>▪ Cancer screenings: <ul style="list-style-type: none"> <li>- flexible sigmoidoscopies and/or screening fiber-optic colonoscopies</li> <li>- fecal occult blood testing</li> <li>- Prostate Specific Antigen (PSA) tests, digital rectal exams</li> </ul> </li> <li>▪ Women's preventive health care: <ul style="list-style-type: none"> <li>- gynecological exam</li> <li>- mammograms</li> <li>- pap smears</li> <li>- CA125 tumor marker</li> <li>- trans-vaginal ultrasound pelvic exam</li> <li>- a manual breast pump</li> <li>- prenatal care</li> <li>- screening and counseling for interpersonal and domestic violence</li> <li>- surgical sterilization</li> </ul> </li> </ul> </li> </ul>	<p>100%</p>	<p>80%, plus you pay any charges billed to you that exceed the allowed amount.</p>

**NOTES:**

- Services include recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA).
- The Plan covers surgical implants and tubal ligation for elective female sterilization which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA). For more information regarding elective sterilization coverage, please visit the Claims Administrator's website or contact Customer Service.
- The Plan covers the full range of preventive contraceptive methods and for patient education/counseling for women of reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply. Refer to Prescription Drugs and Insulin for pharmacy drug coverage.
- Services for complications related to female contraceptive drugs, devices, and services for women of reproductive capacity may be covered under other Plan benefits. Refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.
- The Preventive Care Service list is subject to change due to changes in recommendations and criteria by the USPSTF, ACIP, and HRSA.
- Preventive care services comply with applicable statutes and regulations (i.e., cancer screening services).
- For more information regarding preventive care services, please visit the Claims Administrator's website or contact Customer Service.
- Services to treat an illness/injury diagnosed as a result of preventive care services may be covered under other Plan benefits. Refer to Hospital Inpatient, Hospital Outpatient, Physician Services, etc.
- The following services are covered at the In-Network level of benefits (applying to the In-Network deductible and out-of-pocket maximum, if applicable), and you are not responsible for charges that exceed the allowed amount from providers who are not affiliated with the Claims Administrator. These services may be covered under Hospital Outpatient, Physician Services, or Preventive Care based on the nature of the service(s) provided:
  - voluntary planning of the conception and bearing of children;
  - diagnosis of infertility;
  - testing and treatment of a sexually transmitted disease; and
  - testing of AIDS or other HIV-related conditions.

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**NOT COVERED:**

- a general medical examination requested by a third party for: admission to an old age home, adoption, camp, driving license, immigration and naturalization, insurance certification, marriage, prison, school admission or sports competition
  - services for or related to surrogate pregnancy including diagnostic screening, physician services, reproduction treatments, and prenatal/delivery/postnatal services
  - Services for or related to preventive medical evaluations for purpose of medical research, NCAA sports participation, obtaining employment or insurance, obtaining/maintaining a license of any type, or other administrative or participation exams, unless such preventive medical evaluation would normally have been provided in the absence of the third party request
  - educational classes or programs, except educational classes or programs required by federal law
  - services for or related to lenses, frames, and contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except where eligible under Medical Equipment, Prosthetics, and Supplies
  - treatment services or supplies which are investigative or not medically necessary
  - please refer to the General Exclusions section
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## Reconstructive Surgery

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Reconstructive surgery which is incidental to or following surgery resulting from injury, sickness, or other diseases of the involved body part</li> <li>• Reconstructive surgery performed on a dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician</li> <li>• Treatment of cleft lip and palate when services are scheduled or initiated including dental implants</li> <li>• Elimination or maximum feasible treatment of port wine stains</li> </ul>	<p>For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.</p>	<p>For the level of coverage, refer to Hospital Inpatient, Hospital Outpatient, and Physician Services.</p>

### NOTES:

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

### NOT COVERED:

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

## Skilled Nursing Facility

The Student Health Benefit Plan Covers:	In-Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> <li>• Skilled care ordered by a physician</li> <li>• Room and board</li> <li>• General nursing care</li> <li>• Prescription drugs used during a covered admission</li> <li>• Physical, occupational, and speech therapy</li> </ul>	80%	80%, plus you pay any charges billed to you that exceed the allowed amount.

### NOTES:

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

### NOT COVERED:

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



## Transplant Coverage

The Student Health Benefit Plan Covers:	Blue Distinction Centers for Transplant (BDCT) Providers	Non-Blue Distinction Centers for Transplant (BDCT) Providers
<p>The following medically necessary human organ, bone marrow, cord blood and peripheral stem cell transplant procedures:</p> <ul style="list-style-type: none"> <li>• Allogeneic and syngeneic bone marrow transplant and peripheral stem cell transplant procedures</li> <li>• Autologous bone marrow transplant and peripheral stem cell transplant procedures</li> <li>• Heart</li> <li>• Heart - lung</li> <li>• Kidney – pancreas transplant performed simultaneously (SPK)</li> <li>• Liver – deceased donor and living donor</li> <li>• Lung – single or double</li> <li>• Pancreas transplant – deceased donor and living donor segmental</li> <li>• <ul style="list-style-type: none"> <li>▪ Pancreas Transplant Alone (PTA)</li> <li>▪ Simultaneous Pancreas – Kidney transplant (SPK)</li> <li>▪ Pancreas transplant After Kidney transplant (PAK)</li> </ul> </li> <li>• Small-bowel and small-bowel/liver</li> </ul>	<p>100% of the Transplant Payment Allowance for the transplant admission.</p> <p>If you live more than 50 miles from a BDCT Provider, there may be travel benefits available for expenses directly related to a preauthorized transplant. See NOTES.</p> <p>For services not included in the Transplant Payment Allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.</p>	<p><b>Participating Transplant Provider</b></p> <p>80% of the Transplant Payment Allowance for the transplant admission, plus you pay any charges billed to you that exceed the allowed amount.</p> <p>For services not included in the Transplant Payment Allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.</p> <p><b>Nonparticipating Transplant Provider</b></p> <p><b>NO COVERAGE.</b></p>

### NOTES:

- Kidney transplants when not performed in conjunction with an eligible major transplant noted above and cornea transplants are eligible procedures that are covered on the same basis as any other illness. Refer to Hospital Inpatient and Physician Services.
- Prior authorization is required for human organ, bone marrow, cord blood and peripheral stem cell transplant procedures and should be submitted in writing to the Transplant Coordinator at P. O. Box 64179, St. Paul, Minnesota, 55164, or faxed to 651-662-1624.

- The Plan covers the following kidney donor services when billed under the donor recipient's name and the donor recipient is covered for the kidney transplant under the Plan:
  - potential donor testing;
  - donor evaluation and work-up; and,
  - hospital and professional services related to organ procurement.
- Kidney transplants, when not done in conjunction with an eligible major transplant noted above and cornea transplants are eligible procedures that are covered on the same basis as any other illness. Refer to Hospital Inpatient and Physician Services.
- For members diagnosed with end stage renal disease (ESRD), your provider is required to complete the Centers for Medicare & Medicaid Services (CMS) form 2728 ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. Your provider must send the completed form to CMS and the Claims Administrator. Please verify with your Provider that form 2728 has been completed and submitted.
- Eligible transplant services provided by Participating Transplant Providers will be paid at the Blue Distinction Centers for Transplant (BDCT) Provider level of benefits when the transplant services are not available at a BDCT Provider.
- Travel benefit-Eligible when you travel more than 50 miles to obtain transplant care at a BDCT or when the BDCT provider requires you to stay at or nearby the transplant facility.
  - The Plan covers the patient up to \$50 per day for lodging when purchased at the transplant facility.
  - The Plan covers a companion/caregiver up to \$50 per day for lodging.
  - The Plan covers the lesser of: 1) the IRS medical mileage allowance in effect on the dates of travel per an online web mapping service or, 2) airline ticket price paid. Mileage applies to the patient traveling to and from home and the BDCT only.
  - Total benefit shall not exceed \$5,000 per lifetime.
  - Lodging is eligible when staying at apartments, hotels, motels, or hospital patient lodging facilities and is eligible only when an overnight stay is necessary.
  - Reimbursed expenses are not tax deductible. Consult your tax advisor.

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#### NOT COVERED:

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

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#### DEFINITIONS:

- **BDCT Provider** means a hospital or other institution that has a contract with the Blue Cross and Blue Shield Association\* to provide human organ, bone marrow, cord blood, and peripheral stem cell transplant procedures.

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

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\*An association of independent Blue Cross and Blue Shield Plans.

# GENERAL EXCLUSIONS

The Student Health Benefit Plan does not pay for:

- 1 Treatment, services, or supplies which are not medically necessary.
- 2 Charges for or related to care that is investigative, except for certain routine care for approved clinical trials.
- 3 Any portion of a charge for a covered service or supply that exceeds the allowed amount, except as specified in the Benefit Chart.
- 4 Services that are provided without charge, including services of the clergy.
- 5 Services performed before the effective date of coverage, and services received after your coverage terminates, even though your illness started while coverage was in force.
- 6 Expenses incurred for services, supplies, medical care or treatment received at a health care provider that represents to a patient that he or she will not owe the required cost sharing amount (including, for example, deductibles, copayments, and coinsurance) described in this Plan.
- 7 Services for or related to therapeutic acupuncture, except for the treatment of chronic pain (defined as a duration of at least six (6) months) or for the prevention and treatment of nausea associated with surgery, chemotherapy, or pregnancy.
- 8 Services that are provided to you for the treatment of an employment-related injury for which you are entitled to make a workers' compensation claim.
- 9 Charges that are eligible, paid or payable, under any medical payment, personal injury protection, automobile or other coverage (e.g., homeowner's insurance, boat owner's insurance, liability insurance, etc.) that is payable without regard to fault, including charges for services that are applied toward any deductible, copay or coinsurance requirement of such a policy.
- 10 Services a provider gives to himself/herself or to a close relative (such as spouse, brother, sister, parent, grandparent, and/or child).
- 11 Services needed because you engaged in an illegal occupation, or committed or attempted to commit a felony, unless the services are related to an act of domestic violence or the illegal occupation or felonious act is related to a physical or mental health condition.
- 12 Services to treat illnesses/injuries that occur while on military duty and are recognized by the Veterans Administration as services related to service-connected illnesses/injuries.
- 13 Services for dependents if you have participant-only coverage.
- 14 Services that are prohibited by law or regulation.
- 15 Services which are not within the scope of licensure or certification of a provider.
- 16 Charges for furnishing medical records or reports and associated delivery charges.
- 17 Ambulance transportation services that are not medically necessary for basic or advanced life support.
- 18 Transportation services, including ambulance services that are mainly for your convenience.
- 19 Ambulance transportation costs that exceed the allowable cost applicable to transport from the place of departure to the nearest medical facility equipped to treat the condition (example: facility A is the closest medical facility equipped to treat the condition but you choose to be transported to facility B. The Plan will cover eligible medically necessary ambulance transportation costs that would otherwise apply to transportation to facility A. If you choose to be transported by ambulance to facility B, the cost of transportation services in excess of the eligible ambulance transportation costs that would otherwise apply to transportation to facility A, are not covered under the Plan, and you will be responsible for those costs).

- 20 Travel, transportation, or living expenses, whether or not recommended by a physician, except as specified in the Benefit Chart.
- 21 Services for or related to bariatric surgery.
- 22 Services for or related to mental illness not listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*.
- 23 Services or confinements ordered by a court or law enforcement officer that are not medically necessary.
- 24 Evaluations that are not performed for the purpose of diagnosing or treating mental health or substance abuse conditions such as: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; parental competency; and domestic violence programs.
- 25 Services for or related to room and board for foster care, group homes, incarceration, shelter care, and lodging programs, halfway house services, and skills training.
- 26 Services for or related to intensive behavioral therapy programs for the treatment of autism spectrum disorders including, but not limited to: Intensive Early Intervention Behavioral Therapy Services (IEIBTS); Intensive Behavioral Intervention (IBI); and Lovaas Therapy.
- 27 Services for or related to marital/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or marriage/couples retreats; encounters; or seminars.
- 28 Services for or related to marital/couples counseling.
- 29 Services for or related to therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child's improved functioning); treatment of learning disabilities; therapeutic day care and therapeutic camp services; and hippotherapy (equine movement therapy).
- 30 Charges made by a health care professional for physician/patient telephone consultations.
- 31 Services for or related to substance abuse or addictions not listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*.
- 32 Services for or related to substance abuse interventions (defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person) with the intent of convincing the affected person to enter treatment for the condition.
- 33 Services for or related to therapeutic massage.
- 34 Dentures, regardless of the cause or condition, and any associated services and/or charges including bone grafts, except as covered under Pediatric Dental benefits administered by Delta Denal.
- 35 Dental implants and associated services and/or charges, except as specified in the Benefit Chart.
- 36 Services for or related to the replacement of a damaged dental bridge from an accident-related injury, except as covered under Pediatric Dental benefits administered by Delta Denal.
- 37 Services for or related to oral surgery and anesthesia for the removal of impacted teeth, except as specified in the Benefit Chart.
- 38 Services for or related to oral surgery and anesthesia for removal of a tooth root without removal of the whole tooth and root canal therapy.
- 39 Services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia or facility charges, and bone grafts, except as specified in the Benefit Chart.
- 40 Services to treat bruxism, including dental splints.

- 41 Room and board expenses in a residential hospice facility.
- 42 Admission for diagnostic tests that can be performed on an outpatient basis.
- 43 Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care.
- 44 Personal comfort items, such as telephone, television, etc.
- 45 Communication services provided on an outpatient basis or in the home.
- 46 Services and prescription drugs for or related to gender selection.
- 47 Services and prescription drugs for or related to reproduction treatment including assisted reproductive technology (ART), artificial insemination (AI), and intrauterine insemination (IUI) procedures.
- 48 Services and prescription drugs for or related to gender identity disorder, sex hormones related to surgery, related preparation and follow-up treatment, care and counseling, unless medically necessary as determined by the Claims Administrator prior to receipt of services.
- 49 Services for or related to adoption fees and childbirth classes.
- 50 Services for or related to elective cesarean (C-) section for the purpose of convenience.
- 51 Services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, prenatal/delivery/postnatal services.
- 52 Donor ova or sperm.
- 53 Services for or related to preservation, storage and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as specified in the Benefit Chart.
- 54 Solid or liquid food, standard and specialized infant formula, banked breast milk, nutritional supplements and electrolyte solution, except when administered by tube feeding and as specified in the Benefit Chart.
- 55 Services and supplies that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to: exercise equipment; air purifiers; air conditioners; dehumidifiers; heat/cold appliances; water purifiers; hot tubs; whirlpools; hypoallergenic mattresses; waterbeds; computers and related equipment; car seats, feeding chairs; pillows; food or weight scales; and incontinence pads or pants.
- 56 Modifications to home, vehicle, and/or workplace, including vehicle lifts and ramps.
- 57 Blood pressure monitoring devices.
- 58 Foot orthoses, except as specified in the Benefit Chart.
- 59 Scalp/cranial hair prostheses (wigs).
- 60 Electric or hospital grade breast pumps.
- 61 Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate.
- 62 Services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as specified in the Benefit Chart.
- 63 Premium frames for corrective lenses for children up to the age of 19 that are outside the standard collection.
- 64 Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs.

- 65 Services primarily educational in nature, except as specified in the Benefit Chart.
- 66 Services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible health care provider.
- 67 Physical, occupational and speech therapy services for or related to learning disabilities and disorders, except when medically necessary and provided by an eligible health care provider.
- 68 Services for or related to health clubs and spas.
- 69 Services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and part of specialized therapy for the member's condition.
- 70 Maintenance services.
- 71 Custodial care.
- 72 Services for or related to the LINX™ Reflux Management System for the treatment of gastroesophageal reflux disease (GERD).
- 73 Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); educational therapy (defined as special education classes, tutoring, and other non-medical services normally provided in an educational setting); or forms of non-medical self-care or self-help training including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work hardening programs; etc.; and all related material and products for these programs.
- 74 Services for or related to functional capacity evaluations for vocational purposes and/or the determination of disability or pension benefits.
- 75 Services for or related to the repair of scars and blemishes on skin surfaces.
- 76 Fees, dues, nutritional supplements, food, vitamins, and exercise therapy for or related to weight loss programs.
- 77 Services for or related to cosmetic health services or reconstructive surgery and related services, and treatment for conditions or problems related to cosmetic surgery or services, except as specified in the Benefit Chart.
- 78 Services for or related to travel expenses for a kidney donor; kidney donor expenses for complications incurred after the organ is removed if the donor is not covered under this Plan; and kidney donor expenses when the recipient is not covered under this Plan.
- 79 Services for or related to any treatment, equipment, drug, and/or device that the Claims Administrator determines does not meet generally accepted standards of practice in the medical community for cancer and/or allergy testing and/or treatment: services for or related to homeopathy, or chelation therapy that the Claims Administrator determines is not medically necessary.
- 80 Services for or related to gene therapy as a treatment for inherited or acquired disorders.
- 81 Services for or related to growth hormone replacement therapy except for conditions that meet medical necessity criteria.
- 82 Autopsies.
- 83 Charges for failure to keep scheduled visits.

- 84 Charges for giving injections that can be self-administered.
- 85 Services provided during an e-visit for the sole purpose of: scheduling appointments; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit, except as specified in the Benefit Chart.
- 86 Provider initiated e-mail communications.
- 87 Services provided during a telemedicine visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription medications; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; and, additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
- 88 Facsimile transmission communications between members and providers.
- 89 Services for or related to smoking cessation program fees and/or supplies, except as specified in the Special Features section.
- 90 Charges for over-the-counter drugs, except as specified in the Benefit Chart.
- 91 Vitamin or dietary supplements, except as specified in the Benefit Chart.
- 92 Investigative or non-FDA approved drugs, except as required by law.
- 93 Services for or related to preventive medical evaluations for purpose of medical research, NCAA sports participation, obtaining employment or insurance, obtaining/maintaining a license of any type, or other administrative or participation exams, unless such preventive medical evaluation would normally have been provided in the absence of the third party request.
- 94 A general medical examination requested by a third party for: admission to an old age home, adoption, camp, driving license, immigration and naturalization, insurance certification, marriage, prison, school admission or sports competition.
- 95 Services, supplies, drugs and aftercare for or related to artificial or nonhuman organ implants.
- 96 Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs and aftercare for or related to bone marrow and peripheral stem cell transplant procedures that are considered investigative or not medically necessary.
- 97 Services for or related to fetal tissue transplantation.
- 98 Services for or related to bone marrow or organ transplants, including all related follow-up treatment, exams, and drugs within 365 days after the transplant. Except when provided in conjunction with an eligible major organ transplant, the Plan covers kidney and cornea transplants as standard benefits.
- 99 Injury occurring during the practice or playing of intercollegiate sports under the direction and governance of the University of Minnesota Men's and Women's Intercollegiate Athletic Departments, except as specified under Injuries During Intercollegiate Sports Activities. See page 36.
- 100 Services and supplies for or related to sexual dysfunction.
- 101 Paternal DNA Testing.
- 102 For international students, expenses incurred within the insured person's home country or country of regular domicile.



# TERMINATION OF COVERAGE

## ***Termination Events***

Coverage ends on the earliest of the following dates:

1. For you and your dependents, the date on which the Student Health Benefit Plan terminates.
2. For you and your dependents, the date on which:
  - a. you are no longer eligible.
  - b. you enter military services for duty lasting more than 31 days.
3. For the spouse, the date the spouse is no longer eligible for coverage. This is the date on which the participant and spouse divorce.
4. For a dependent child, the date the dependent child is no longer eligible for coverage. This is the date on which:
  - a. a covered stepchild is no longer eligible because the participant and spouse divorce.
  - b. the dependent child reaches the dependent-child age limit.
  - c. the disabled dependent is no longer eligible.
5. The date on which the enrolled and domestic partner submit an "Affidavit of Termination of Domestic Partnership."

## ***Extension of Benefits***

If you or your dependent is confined as an inpatient on the date coverage ends due to the replacement of the Claims Administrator, the Student Health Benefit Plan will automatically extend coverage until the date you or your dependent is discharged from the facility or the date Plan maximums are reached, whichever is earlier. Coverage is extended only for the person who is confined as an inpatient, and only for inpatient charges incurred during the admission. For purposes of this provision, "replacement" means that the administrative service agreement with the Claims Administrator has been terminated and your participant maintains continuous group coverage with a new claims administrator or insurer.

# COORDINATION OF BENEFITS

This section applies when you have health care coverage under more than one (1) plan, as defined below. If this section applies, you should look at the Order of Benefits Rules first to determine which plan determines benefits first. Your benefits under This Student Health Benefit Plan are not reduced if the Order of Benefits Rules require this Plan to pay first. Your benefits under This Student Health Benefit Plan may be reduced if another plan pays first.

## ***Definitions***

These definitions apply only to this section.

1. The term “plan” means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:
  - a. group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, individual practice coverage, and group coverage other than school accident-type coverage
  - b. coverage under a government plan or required or provided by law;
  - c. individual coverage; and
  - d. the medical payment (“medpay”) or personal injury protection benefit available to you under an automobile insurance policy.

Therefore, “plan” does not include:

- a. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time);
- b. any benefits that, by law, are excess to any private or other nongovernmental program; or
- c. hospital indemnity, specified accident, specified disease, or limited benefit insurance policies.

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

2. The term “This Student Health Benefit Plan” means the part of the Plan document that provides health care benefits.
3. “Primary Plan/Secondary Plan” is determined by the Order of Benefits Rules.

When This Plan is a Primary Plan, its benefits are determined before any other plan and without considering the other plan’s benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan’s benefits.

When you are covered under more than two (2) plans, This Plan may be a Primary Plan to some plans, and may be a Secondary Plan to other plans.

Notes:

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

4. "Allowable expense" means the necessary, reasonable, and customary items of expense for health care, covered at least in part by one (1) or more plans covering the person making the claim. "Allowable expense" does not include an item or expense that exceeds benefits that are limited by statute or This Student Health Benefit Plan. "Allowable Expense" does not include outpatient prescription drugs, except those eligible under Medicare (see number three (3) above).

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

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

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

## ***Order of Benefits Rules***

1. General: When a claim is filed under This Student Health Benefit Plan and another plan, This Student Health Benefit Plan is a Secondary Plan and determines benefits after the other plan, unless:
  - a. the other plan has rules coordinating its benefits with This Student Health Benefit Plan's benefits; and
  - b. the other plan's rules and This Student Health Benefit Plan's rules, in part 2. below, require This Student Health Benefit Plan to determine benefits before the other plan.
2. Rules: This Student Health Benefit Plan determines benefits using the first of the following rules that applies:
  - a. The plan that covers a person as automobile insurance medical payment ("medpay") or personal injury protection coverage determines benefits before a plan that covers a person as a group health plan enrollee.
  - b. Nondependent/dependent: The plan that covers the person as a student, member, or subscriber (that is, other than as a dependent) determines its benefits before the plan that covers the person as a dependent.
  - c. Dependent child of parents not separated or divorced: When This Student Health Benefit Plan and another plan cover the same child as a dependent of different persons, called "parents":
    - 1) the plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year; but
    - 2) if both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time.

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

- d. Dependent child of parents divorced or separated or separated through termination of a domestic partner relationship: If two (2) or more plans cover a dependent child of divorced or separated parents, This Student Health Benefit Plan determines benefits in this order:
  - 1) first, the plan of the parent with physical custody of the child;
  - 2) then, the plan that covers the spouse of the parent with physical custody of the child;
  - 3) finally, the plan that covers the parent not having physical custody of the child; or
  - 4) in the case of joint physical custody, b. above applies.

However, if the court decree requires one (1) of the parents to be responsible for the health care expenses of the child, and the plan that covers that parent has actual knowledge of that requirement, that plan determines benefits first. This does not apply to any claim determination period or plan year during which any benefits are actually paid or provided before the plan has that actual knowledge.

- e. Active/inactive employee: The Plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) determines benefits before a plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if as a result the plans do not agree on the order of benefits, then this rule is ignored.
- f. Longer/shorter length of coverage: If none of the above determines the order of benefits, the plan that has covered an employee, member, or subscriber longer determines benefits before the plan that has covered that person for a shorter time.

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

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

When the sum of:

- a. the benefits payable for allowable medical expenses under This Student Health Benefit Plan, without applying coordination of benefits; and
- b. the benefits payable for allowable medical expenses under the other plans, without applying coordination of benefits or a similar provision, whether or not claim is made, exceeds those allowable medical expenses in a claim determination period. In that case, the benefits of This Student Health Benefit Plan are reduced so that benefits payable under all plans do not exceed allowable medical expenses.

When medical benefits of This Student Health Benefit Plan are reduced, each benefit is reduced in proportion and charged against any applicable benefit limit of This Student Health Benefit Plan.

### ***Right to Receive and Release Needed Information***

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

### ***Facility of Payment***

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

### ***Right of Recovery***

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

1. the persons This Student Health Benefit Plan paid or for whom This Plan has paid;
2. insurance companies; and
3. other organizations.

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

# REIMBURSEMENT AND SUBROGATION

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

## The Plan's Right of Subrogation

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

## Obligation to Reimburse the Plan

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

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

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

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

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

## Duty to Cooperate

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

1. the potential or actual claims that you and your dependents have or may have;
2. the identity of any and all parties who are or may be liable; and
3. the date and nature of the accident, injury, sickness or condition for which the Plan has or will pay benefits and for which it may be entitled to subrogate or be reimbursed.

You and your dependents must provide this information as soon as possible, and in any event, before the earlier of the date on which you, your dependents, your attorneys or other representatives:

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

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

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

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

### **Attorneys' Fees and Other Expenses You Incur**

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

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

### **What May Happen to Your Future Benefits**

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

### **Interpretation**

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

# GENERAL PROVISIONS

## ***Student Health Benefit Plan Administration***

### **Student Health Benefit Plan Administrator**

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

### **Powers and Duties of the Student Health Benefit Plan Administrator**

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

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

### **Actions of the Student Health Benefit Plan Administrator**

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

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

## ***Termination or Changes to the Student Health Benefit Plan***

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

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

## ***Funding***

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

## ***Controlling Law***

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



## ***XVIII: Notice of Privacy Practices***

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

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

### **A. University of Minnesota-Sponsored Student Health Benefit Plan Covered by this Notice**

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

### **B. Your Protected Health Information**

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

### **C. How the Student Health Benefit Plan Uses and Discloses your PHI**

**The Student Health Benefit Plan may use and disclose your PHI:**

- **For Treatment** or the coordination of your care. For example, we may disclose information about your medical providers to emergency physicians to help them obtain information that will help in providing medical care to you.
- **For Payment** purposes, such as determining your eligibility for benefits, facilitating payment for services you receive, and coordinating benefits with other plans you may have. For example, we may share your PHI with third party administrators we hire to process claims and provider other administrative services.
- **For Health Care Operations** necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, the Student Health Benefit Plan might suggest a disease management or wellness program that could help improve your health, or we may analyze data to determine how to improve services. Although our plan administrators are independent organizations, contracted separately with the University to safeguard your PHI, they may share PHI for the treatment, health care, and payment operations described in this notice.
- **To the Plan Sponsor**, the University of Minnesota, in order to provide summary health information and enrollment and disenrollment information. In addition, provided that the University of Minnesota as the Plan Sponsor agrees, as required by federal law, to certain restrictions on its use and disclosure of any information we share, we may share other health information with the Plan Sponsor for purposes of plan administration.

- **To the Health Plan Components within the Student Health Benefit Plan** in order to facilitate claims payment and certain health care operations of the other plans.
- **To Persons Involved With Your Care** or those who help pay for your care (such as a family member) when you are incapacitated, in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interest.
- **To Organizations Referred to as Business Associates** that perform functions on our behalf or provide us with services, if the information is necessary for such functions or services. For example, we periodically retain an organization to audit our Plan administrators, to assure we are receiving high quality services. Such an auditing organization and any of our other business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
- **For Plan Evaluation**, determining plan rates, underwriting, or making decisions about enhancements and modifications for future plans and coverage. We do not use and are not permitted to use any PHI that is genetic information for underwriting purposes.
- **For Public Health Activities** such as reporting or preventing disease outbreaks.
- **For Reporting Victims of Abuse, Neglect, or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits, and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, subpoena, discovery request, or other lawful process.
- **For Law Enforcement Purposes** such as responding to requests from administrative agencies, responding to requests to locate missing persons, reporting criminal activity, or providing information about victims of crime.
- **To Provide Information Regarding Decedents** to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes** to entities that handle procurement, banking, or transplantation of organs, eyes, or tissue to facilitate donation and transplantation.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets applicable privacy law requirements.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public. For example, we may disclose information to public health agencies or law enforcement authorities in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as national security and intelligence activities, protective services for the President of the United States and others, and military and veteran activities (if you are a member of the Armed Forces). If you are an inmate at a correctional institution, we may use or disclose your PHI to provide health care to you or to protect your health and safety or that of others or the security of the correctional institution.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers' compensation laws that govern job-related injuries or illness.

**The Student Health Benefit Plan will not use or disclose your PHI without your written authorization:**

- **For marketing purposes**, unless the marketing is in the form of a face-to-face interaction with you (such as at a University health and benefits fair) or involves providing you with a gift of nominal value (such as mailing you a calendar highlighting certain dates related to your Wellness Program or health plan coverage).
- **As part of a sale to a third party**, unless the transaction is specifically permitted under HIPAA, such as the sale of an entire business operation.
- **Where your PHI is psychotherapy notes**, unless the use and disclosure is required by law, is at issue in a legal action brought by you, is related to treatment, payment, or healthcare operations, or certain other limited circumstances such as oversight of the provider who treated you.
- **For any other purpose** not identified in this Notice.

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

**D. Your Rights Concerning your PHI:**

- **You have the right to ask to restrict** uses or disclosures of your PHI for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. Any such requests must be in writing and must state the specific restriction you are requesting. Submit your request in writing to the address listed in the Contact Information section of this Notice. Please note that while we will try to honor your request, we are not required to agree to any restriction.
- **You have the right to ask to receive confidential communications** of your PHI in a certain manner or at a certain place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where you indicate that a disclosure of all or part of your PHI could endanger you. Your request must be made in writing or via email using the information listed in the Contact Information section of this Notice.
- **You have the right to inspect and obtain a copy** of your PHI that is maintained in a "designated record set." The designated record set consists of records used in making payment, claims determinations, medical management, and other decisions. You must make a written request to inspect and copy your PHI. Mail your request to the address listed in the Contact Information section included in this Notice. We may charge a reasonable fee for any copies. In certain limited circumstances, we may deny your request to inspect and copy your PHI. If we deny your request, you have the right to have the denial reviewed. If we maintain an electronic health record containing your health information, when and if we are required by law, you will have the right to request that we send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.
- **You have the right to ask to amend PHI** we maintain about you if you believe the information is wrong or incomplete. Your request must be in writing and must provide the reasons for the requested amendment. Mail your request to the address listed in the Contact Information section of this Notice. If we deny your request, you may have a statement of your disagreement added to your health information.

- **You have the right to receive an accounting** of certain disclosures of your PHI made by the Student Health Benefit Plan during the six years prior to your request. This accounting will not include disclosures of information made: (a) for treatment, payment, and health care operations purposes; (b) to you or pursuant to your authorization; (c) to correctional institutions or law enforcement officials; and (d) certain other disclosures for which federal law does not require us to provide an accounting. Your request must be in writing and mailed to the address listed in the Contact Information section of this Notice. If you make multiple requests for an accounting of disclosures in any 12 month period, we may charge you a reasonable fee to provide the accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Submit your request in writing by mail or email using the information listed in the Contact Information section of this Notice.

## **E. Complaints**

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

## **F. The Student Health Benefit Plan's Duties Concerning your PHI**

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

## **G. Contact Information**

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

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

612-624-0627 or 1-800-232-9017

[umshbo@umn.edu](mailto:umshbo@umn.edu)

**Effective Date of this Notice: September 23, 2013**

# GLOSSARY OF COMMON TERMS

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

<b>90dayRx</b>	Participating 90dayRx Retail Pharmacies and Mail Service Pharmacy used for the dispensing of a 90-day supply of long-term prescription drug refills.
<b>Admission</b>	A period of one (1) or more days and nights while you occupy a bed and receive inpatient care in a facility.
<b>Advanced practice nurses</b>	Licensed registered nurses who have gained additional knowledge and skills through an organized program of study and clinical experience that meets the criteria for advanced practice established by the professional nursing organization having the authority to certify the registered nurse in the advanced nursing practice. Advanced practice nurses include clinical nurse specialists (C.N.S.), nurse practitioners (N.P.), certified registered nurse anesthetists (C.R.N.A.), and certified nurse midwives (C.N.M.).
<b>Allowed amount</b>	The amount upon which payment is based for a given covered service for a specific provider. The allowed amount may vary from one provider to another for the same service. All benefits are based on the allowed amount, except as specified in the Benefit Chart.

## **The Allowed Amount for Participating Providers**

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

Through annual or global settlements or other special arrangements with Participating Providers the Claims Administrator may prospectively or subsequently pay a different amount to a Participating Provider without reprocessing individual claims. Such annual or global payments will not affect or cause any change in the amount you paid at the time your claim was processed.

If the payment to the provider is decreased, the amount of the decrease is credited to the Plan, and the percentage of the allowed amount paid by the Plan is lower than the stated percentage for the covered service. If the payment to the provider is increased, the Plan pays that cost on your behalf, and the percentage of the allowed amount paid is higher than the stated percentage.

## **Qualifications Applicable to All Nonparticipating Providers**

In determining the allowed amount for Nonparticipating Providers, the Claims Administrator makes no representations that this allowed amount is a usual, customary, or reasonable charge from a provider. The allowed amount is the amount that the Plan will pay for a covered service. The Plan will pay this amount to you. The determination of the allowed amount is subject to all of the Claims Administrator's business rules as defined in the Claims Administrator Provider Policy and Procedure Manual.

As a result, the Claims Administrator may bundle services or take multiple procedure discounts and/or reductions as a result of the procedures performed and billed on the claim. No fee schedule amounts include any applicable tax.

#### **The Allowed Amount for Nonparticipating Providers in Minnesota**

For Nonparticipating Provider services within Minnesota, except those described under Special Circumstances below, the allowed amount will be based upon one of the following payment options to be determined by the Claims Administrator at its discretion: (1) a percentage, not less than 100%, of the Medicare Allowed Charge for the same or similar service; (2) a percentage of billed charges; or (3) pricing based upon a nationwide provider reimbursement database. The payment option selected by the Claims Administrator may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare Allowed Charge is not available, the pricing method is determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the Claims Administrator.

#### **The Allowed Amount for All Nonparticipating Provider Services Outside Minnesota**

For Nonparticipating Provider services outside of Minnesota, except those described under Special Circumstances below, the allowed amount will be based upon one of the following payment options to be determined at the Claims Administrator's discretion: (1) a percentage, not less than 100%, of the Medicare Allowed Charge for the same or similar service; (2) a percentage of billed charges; or (3) pricing based upon a nationwide provider reimbursement database. The payment option selected by the Claims Administrator may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare Allowed Charge is not available, the pricing method is determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the Claims Administrator.

#### **Special Circumstances**

There may be circumstances where you require immediate medical or surgical care and you do not have the opportunity to select the provider of care, such as in the event of a medical emergency. Some hospital-based providers (e.g., anesthesiologists) may not be participating providers. Typically, when you receive care from nonparticipating providers, you are responsible for the difference between the allowed amount and the provider's billed charges. However, in circumstances where you needed care, and were not able to choose the provider who rendered such care, the Claims Administrator may pay an additional amount. The extent of reimbursement in these circumstances may also be subject to federal law. The extent of reimbursement in certain medical emergency circumstances may also be subject to federal law. Refer to Emergency Care for benefits.

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

<b>Artificial Insemination (AI)</b>	The introduction of semen from a donor (which may have been preserved as a specimen), into a woman's vagina, cervical canal, or uterus by means other than sexual intercourse.
<b>Assisted Reproductive Technologies (ART)</b>	Fertility treatments in which both eggs and sperm are handled. In general, ART procedures involve surgically removing eggs from a woman's ovaries, combining them with sperm in the laboratory, and returning them to the woman's body or donating them to another woman. Such treatments do not include procedures in which only sperm are handled (i.e., intrauterine insemination (IUI), or artificial insemination (AI)), or procedures in which a woman takes medicine only to stimulate egg production without the intention of having eggs retrieved.
<b>Attending health care professional</b>	A health care professional with primary responsibility for the care provided to a sick or injured person.
<b>BlueCard Network Provider</b>	Providers who have entered into a specific network contract with the local Blue Cross and/or Blue Shield Plan outside of Minnesota.
<b>BlueCard Program</b>	A national Blue Cross and Blue Shield program in which employees and dependents can receive health plan benefits while traveling or living outside the state of Minnesota. Employees and dependents must show their membership ID to secure benefits.
<b>Care/case management plan</b>	A plan for health care services developed for a specific patient by a care/case manager after an assessment of the patient's condition in collaboration with the patient and the patient's health care team. The plan sets forth both the immediate and the ongoing skilled health care needs of the patient to sustain or achieve optimal health status.
<b>Care Coordination</b>	Organized, information-driven patient care activities intended to facilitate the appropriate responses to your health care needs across the continuum of care.
<b>Claim</b>	<p>A written submission from your provider (or you when you use Nonparticipating Providers) to the Claims Administrator. Most claims are submitted electronically. The claim tells the Claims Administrator what services the provider delivered to you. In some cases, the Claims Administrator may require additional information from the provider or you before a determination can be made. When this occurs, work with your provider to return the information to the Claims Administrator promptly. If the provider delivered a service that is not covered, the claim will be denied, meaning no payment is allowed.</p> <p>Providers are required to use certain codes to explain the care they give you. The provider's medical records must support the codes being used. The Claims Administrator may not change the codes a provider uses on a claim. If you believe your provider has not used the right codes on your claim, you will need to contact your provider.</p>
<b>Claims Administrator</b>	Blue Cross and Blue Shield of Minnesota (Blue Cross).
<b>Coinsurance</b>	The percentage of the allowed amount you must pay for certain covered services after you have paid any applicable deductibles and copays and until you reach your out-of-pocket and/or intermediate maximum. For covered services from In-Network and Extended Network (if applicable) Providers, coinsurance is calculated based on the lesser of the allowed amount or the In-Network and Extended Network (if applicable) Provider's billed charge.

Because payment amounts are negotiated with In-Network and Extended Network (if applicable) Providers to achieve overall lower costs, the allowed amount for In-Network and Extended Network (if applicable) Providers is generally, but not always, lower than the billed charge. However, the amount used to calculate your coinsurance will not exceed the billed charge. When your coinsurance is calculated on the billed charge rather than the allowed amount for In-Network and Extended Network (if applicable) Providers, the percentage of the allowed amount paid by the Claims Administrator will be greater than the stated percentage.

For covered services from Nonparticipating Providers, coinsurance is calculated based on the allowed amount. In addition, you are responsible for any excess charge over the allowed amount.

Your coinsurance and deductible amount will be based on the negotiated payment amount the Claims Administrator has established with the provider or the provider's charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed.

In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance and deductible calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements the Claims Administrator may receive from other parties.

#### Coinsurance Example:

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

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

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

#### **Compound drug**

A prescription where two (2) or more drugs/medications are mixed together. All of these drugs/medications must be FDA-approved. The end product must not be available in an equivalent commercial form. A prescription will not be considered a compound prescription if it is reconstituted or if, to the active ingredient, only water or sodium chloride solution are added. The compound must also be FDA-approved for use in the condition being treated and in the dosage form being dispensed.



<b>Comprehensive pain management program</b>	<p>A multidisciplinary program including, at a minimum, the following components:</p> <ul style="list-style-type: none"> <li>a comprehensive physical and psychological evaluation;</li> <li>physical/occupation therapies;</li> <li>a multidisciplinary treatment plan; and</li> <li>a method to report clinical outcomes.</li> </ul>
<b>Copay</b>	<p>The dollar amount you must pay for certain covered services. The Benefit Chart lists the copays and services that require copays.</p> <p>A negotiated payment amount with the provider for a service requiring a copay will not change the dollar amount of the copay.</p>
<b>Cosmetic services</b>	Surgery and other services performed primarily to enhance or otherwise alter physical appearance without correcting or improving a physiological function.
<b>Covered services</b>	A health service or supply that is eligible for benefits when performed and billed by an eligible provider. You incur a charge on the date a service is received or a supply or a drug is purchased.
<b>Custodial care</b>	Services and supplies that are primarily intended to help someone meet personal needs or to assist in activities of daily living, such as giving medicine that can usually be taken without help, preparing special foods, helping someone walk, get in and out of bed, dress, eat, bathe and use the toilet. These services do not seek to cure, are performed regularly as part of a routine or schedule, and do not need to be provided directly or indirectly by a health care professional.
<b>Cycle</b>	One (1) partial or complete fertilization attempt extending through the implantation phase only.
<b>Day treatment</b>	Behavioral health services that may include a combination of group and individual therapy or counseling for a minimum of three (3) hours per day, three (3) to five (5) days per week.
<b>Dependent</b>	Your spouse, child to the dependent child age limit specified in the Eligibility section, child whom you or your spouse have adopted or been appointed legal guardian to the dependent child age limit specified in the Eligibility section, disabled dependent or dependent child as defined in the Eligibility section, or any other person whom state or federal law requires be treated as a dependent under this Plan.
<b>Drug therapy supply</b>	A disposable article intended for use in administering or monitoring the therapeutic effect of a drug.
<b>Durable medical equipment</b>	<p>Medical equipment prescribed by a physician that meets each of the following requirements:</p> <ol style="list-style-type: none"> <li>1. able to withstand repeated use;</li> <li>2. used primarily for a medical purpose;</li> <li>3. generally not useful in the absence of illness or injury;</li> <li>4. determined to be reasonable and necessary; and</li> <li>5. represents the most cost-effective alternative.</li> </ol>

<b>E-Visit</b>	A patient initiated, limited online evaluation and management health care service provided by a physician or other qualified health care provider using the internet or similar secure communications network to communicate with an established patient.
<b>Eligible credits</b>	Eligible credits are credits registered for that contribute towards the total count under the enrollment guidelines for being assessed mandatory Student Services Fee and also require proof of health insurance or result in a charge for the Student Health Benefit Plan.
<b>Emergency hold</b>	A process defined in Minnesota law that allows a provider to place a person who is considered to be a danger to themselves or others, in a hospital involuntarily for up to 72 hours, excluding Saturdays, Sundays, and legal holidays, to allow for evaluation and treatment of mental health and/or substance abuse issues.
<b>Enrollment date</b>	The first day of coverage, for each academic semester or academic summer session.
<b>Facility</b>	A provider that is a hospital, skilled nursing facility, residential behavioral health treatment facility, or outpatient behavioral health treatment facility licensed under state law, in the state in which it is located to provide the health services billed by that facility. Facility may also include a licensed home infusion therapy provider, freestanding ambulatory surgical center, home health agency, or freestanding birthing center when services are billed on a facility claim.
<b>Family therapy</b>	Behavioral health therapy intended to treat an individual, diagnosed with a mental health condition, within the context of family relationships.
<b>Foot orthoses</b>	Appliances or devices used to stabilize, support, align, or immobilize the foot in order to prevent deformity, protect against injury, or assist with function. Foot orthoses generally refer to orthopedic shoes, and devices or inserts that are placed in shoes including heel wedges and arch supports. Foot orthoses are used to decrease pain, increase function, correct some foot deformities, and provide shock absorption to the foot. Orthoses can be classified as pre-fabricated or custom made. A pre-fabricated orthosis is manufactured in quantity and not designed for a specific patient. A custom-fitted orthosis is specifically made for an individual patient.
<b>Freestanding ambulatory surgical center</b>	A provider who facilitates medical and surgical services to sick and injured persons on an outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.) and/or registered nurses (R.N.). A freestanding ambulatory surgical center is not part of a hospital, clinic, doctor's office, or other health care professional's office.
<b>Group home</b>	A supportive living arrangement offering a combination of in-house and community resource services. The emphasis is on securing community resources for most daily programming and employment.
<b>Group therapy</b>	Behavioral health therapy conducted with multiple patients

<b>Habilitative Services</b>	Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to attain, maintain, or improve daily living skills or functions never learned or acquired due to a disabling condition.
<b>Halfway house</b>	Specialized residences for individuals who no longer require the complete facilities of a hospital or institution but are not yet prepared to return to independent living.
<b>Health care professional</b>	A health care professional, licensed for independent practice, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that health care professional. Health care professionals include only physicians, chiropractors, mental health professionals, advanced practice nurses, physician assistants, audiologists, physical, speech and occupational therapists, licensed nutritionists, licensed registered dietitians, and licensed acupuncture practitioners. Health care professional also includes supervised employees of: Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services and doctors of medicine, osteopathy, chiropractic, or dental surgery.
<b>Home health agency</b>	A Medicare approved or other preapproved facility that sends health professionals and home health aides into a person's home to provide health services.
<b>Hospice care</b>	A coordinated set of services provided at home or in an institutional setting for covered individuals suffering from a terminal disease or condition.
<b>Hospital</b>	A facility that provides diagnostic, therapeutic and surgical services to sick and injured persons on an inpatient or outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.) or osteopathy (D.O.). A hospital provides 24-hour-a-day professional registered nursing (R.N.) services.
<b>Host Blue</b>	A Blue Cross and/or Blue Shield organization outside of Minnesota that has contractual relationships with Participating Providers in its designated service area that require such Participating Providers to provide services to members of other Blue Cross and/or Blue Shield organizations.
<b>Illness</b>	A sickness, injury, pregnancy, mental illness, substance abuse, or condition involving a physical disorder.
<b>In-Network Provider</b>	A provider that has entered into a specific network contract with the Claims Administrator for this Plan or with the local Blue Cross and/or Blue Shield Plan. Refer to the Benefit Chart and Coverage Information sections for network details.
<b>Infertility testing</b>	Services associated with establishing the underlying medical condition or cause of infertility. This may include the evaluation of female factors (i.e., ovulatory, tubal, or uterine function), male factors (i.e., semen analysis or urological testing) or both and involves physical examination, laboratory studies and diagnostic testing performed solely to rule out causes of infertility or establish an infertility diagnosis.
<b>Intensive Outpatient Programs (IOP)</b>	A behavioral health care service setting that provides structured multidisciplinary diagnostic and therapeutic services. IOPs operate at least three (3) hours per day, three (3) days per week. Substance Abuse treatment is typically provided in an IOP setting. Some IOPs provide treatment for mental

health disorders.

**Intrauterine Insemination (IUI)** A specific method of artificial insemination in which semen is introduced directly into the uterus.

**Investigative** A drug, device, diagnostic procedure, technology, or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. The Claims Administrator bases its decision upon an examination of the following reliable evidence, none of which is determinative in and of itself:

1. the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. the drug, device, diagnostic procedure, technology, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials (Phase I clinical trials determine the safe dosages of medication for Phase II trials and define acute effects on normal tissue. Phase II clinical trials determine clinical response in a defined patient setting. If significant activity is observed in any disease during Phase II, further clinical trials usually study a comparison of the experimental treatment with the standard treatment in Phase III trials. Phase III trials are typically quite large and require many patients to determine if a treatment improves outcomes in a large population of patients);
3. medically reasonable conclusions establishing its safety, effectiveness, or effect on health outcomes have not been established. For purposes of this subparagraph, a drug, device, diagnostic procedure, technology, or medical treatment or procedure shall not be considered investigative if reliable evidence shows that it is safe and effective for the treatment of a particular patient.

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

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

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

**Maintenance Service** Services that are neither habilitative nor rehabilitative that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and part of specialized therapy for the member's condition.

**Marital/couples counseling** Behavioral health care services for the primary purpose of working through relationship issues.

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

<b>Medical emergency</b>	Medically necessary care which a reasonable layperson believes is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the patient in serious jeopardy.
<b>Medically necessary</b>	Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on creditable scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.
<b>Medicare</b>	A federal health insurance program established under Title XVIII of the Social Security Act. Medicare is a program for people age 65 or older; some people with disabilities under age 65; and people with end-stage renal disease. The program includes Part A, Part B and Part D. Part A generally covers some costs of inpatient care in hospitals and skilled nursing facilities. Part B generally covers some costs of physician, medical, and other services. Part D generally covers outpatient prescription drugs defined as those drugs covered under the Medicaid program plus insulin, insulin-related supplies, certain vaccines, and smoking cessation agents. Medicare Parts A, B and D do not pay the entire cost of services and are subject to cost sharing requirements and certain benefit limitations.
<b>Medicare allowed charge</b>	<p>The charge that Medicare would authorize as the cost of a service or supply from a provider that participates in Medicare. The Medicare allowed charge is adjusted by location in the United States according to Geographic Practice Cost Indices (GPCIs) calculated by Medicare. The Medicare allowed charge for covered inpatient care is based upon the Acute Hospital Inpatient Prospective Payment System (PPS). The Medicare allowed charge does not include additional amounts, such as Disproportionate Share Hospital, Direct Graduate Medical Education, outlier amounts or other charges that are not included in the Prospective Payment System amount. Payment for physician services is based solely upon the Medicare Physician Fee Schedule.</p> <p>The determination of the allowed amount is subject to all Medicare payment rules. As a result, the Claims Administrator may bundle services or take multiple procedure discounts and/or other reductions consistent with Medicare payment procedures resulting from the procedures performed and billed on the claim.</p> <p>The Medicare allowable charge that is current as of the time the services are provided will be the amount that is used in determining the allowed amount.</p>

<b>Mental health care professional</b>	A psychiatrist, psychologist, licensed independent clinical social worker, marriage and family therapist, nurse practitioner or a clinical nurse specialist licensed for independent practice that provides treatment for mental health disorders.
<b>Mental illness</b>	A mental disorder as defined in the most current editions of the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM). It does not include alcohol or drug dependence, nondependent abuse of drugs, or developmental disability.
<b>Mobile crisis services</b>	Face-to-face short term, intensive behavioral health care services initiated during a behavioral health crisis or emergency. This service may be provided on-site by a mobile team outside of an inpatient hospital setting or nursing facility. Services can be available 24 hours a day, seven (7) days a week, 365 days per year.
<b>Neuro-psychological examinations</b>	Examinations for diagnosing brain dysfunction or damage and central nervous system disorders or injury. Services may include interviews, consultations and testing to assess neurological function associated with certain behaviors.
<b>Nonparticipating Provider</b>	A provider that has not entered into a network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan.
<b>Opioid treatment</b>	Treatment that uses methadone as a maintenance drug to control withdrawal symptoms for opioid addiction.
<b>Out-of-Network Provider</b>	A Claims Administrator network contracted provider that is not contracted In-Network specific to this Plan (which may also be referred to as an Out-of-Network Participating Provider); and Nonparticipating Providers.
<b>Out-of-pocket maximum</b>	<p>The most each person must pay each applicable plan or calendar year toward the allowed amount for covered services.</p> <p>After a person reaches the out-of-pocket maximum, the Plan pays 100% of the allowed amount for covered services for that person for the rest of the applicable plan or calendar year. The Benefit Chart lists the out-of-pocket maximum amounts.</p>
<b>Outpatient behavioral health treatment facility</b>	A facility that provides outpatient treatment, by or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.), for mental health disorders, alcoholism, substance abuse, or drug addiction. An outpatient behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
<b>Outpatient care</b>	Health services a patient receives without being admitted to a facility as an inpatient. Care received at ambulatory surgery centers is considered outpatient care.
<b>Palliative care</b>	Any eligible treatment or service specifically designed to alleviate the physical, psychological, psychosocial, or spiritual impact of a disease, rather than providing a cure for members with a new or established diagnosis of a progressive, debilitating illness. Services may include medical, spiritual, or psychological interventions focused on improving quality of life by reducing or eliminating physical symptoms, enabling a patient to address psychological and spiritual problems, and supporting the patient and family.

<b>Partial programs</b>	An intensive structured behavioral health care setting that provides medically supervised diagnostic and therapeutic services. Partial programs operate five (5) to six (6) hours per day, five (5) days per week although some patients may not require daily attendance.
<b>Participating Pharmacy</b>	A nationwide pharmaceutical provider that participates in a network for the dispensing of prescription drugs.
<b>Participating Provider</b>	A provider who has entered into either a specific network contract or a general broader network contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Plan.
<b>Physician</b>	A doctor of medicine (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), or optometry (O.D.) practicing within the scope of his or her license.
<b>Place of service</b>	<p>Industry standard claim submission standards (established by the Medicare program) used by clinic and hospital providers.</p> <p>Providers use different types of claim forms to bill for services based on the “place of service.” Generally, the place of service is either a clinic or facility. The benefit paid for a service is based on provider billing and the place of service. For example, the benefits for diagnostic imaging performed in a physician’s office may be different than diagnostic imaging delivered in an outpatient facility.</p>
<b>Plan</b>	The plan of benefits established by the Plan Administrator.
<b>Plan year</b>	August 21, 2017 to August 19, 2018
<b>Preferred drug list</b>	A list of prescription drugs and drug therapy supplies used by patients in an ambulatory care setting. Over-the-counter drugs, injectable medications, and drug therapy supplies are not included in your specified preferred drug list unless they are specifically listed.
<b>Prescription drugs</b>	Drugs, including insulin, that are required by federal law to be dispensed only by prescription of a health professional who is authorized by law to prescribe the drug.
<b>Provider</b>	A health care professional licensed, certified or otherwise qualified under state law, in the state in which services are rendered, to provide the health services billed by that provider and a health care facility licensed under state law in the state in which it is located to provide the health services billed by that facility. Provider includes pharmacies, medical supply companies, independent laboratories ambulances, freestanding ambulatory surgical centers, home infusion therapy providers, and also home health agencies.

<b>Qualifying creditable coverage</b>	Health coverage provided through an individual policy, a self-funded or fully-insured group health plan offered by a public or private employer, Medicare, MinnesotaCare, Medical Assistance (Medicaid), General Assistance Medical Care, the Minnesota Comprehensive Health Association (MCHA), TRICARE, Federal Employees Health Benefit Plan (FEHBP), Medical care program of the Indian Health Service of a tribal organization, a state health benefit risk pool, a Peace Corps health plan, Minnesota Employee Insurance Program (MEIP), Public Employee Insurance Program (PEIP), any plan established or maintained by a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan; the Children's Health Insurance Program (CHIP), or any plan similar to any of the above plans provided in this state or in another state as determined by the Minnesota Commissioners of Commerce or Health.
<b>Rehabilitative Services</b>	Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to regain, maintain, or prevent deterioration of daily living skills or functions acquired but then lost or impaired due to illness, injury, or disabling condition.
<b>Reproduction treatment</b>	Treatment to enhance the reproductive ability among patients experiencing infertility, after a confirmed diagnosis of infertility has been established due to either female, male factors or unknown causes. Treatment may involve oral and/or injectable medications, surgery, artificial insemination, assisted reproductive technologies or a combination of these.
<b>Residential behavioral health treatment facility</b>	A facility licensed under state law in the state in which it is located that provides treatment, by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.), for mental health disorders, alcoholism, substance abuse or substance addiction. The facility provides continuous, 24-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day. A residential behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.
<b>Respite care</b>	Short-term inpatient or home care provided to the patient when necessary to relieve family members or other persons caring for the patient.
<b>Retail health clinic</b>	A clinic located in a retail establishment or worksite. The clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold). If the presenting symptoms are not on the list, the member will be directed to seek services from a physician or hospital. Retail health clinics are staffed by eligible nurse practitioners or other eligible providers that have a practice arrangement with a physician. The list of available medical services and/or treatable symptoms is available at the retail health clinic. Access to retail health clinic services is available on a walk-in basis.
<b>Retail pharmacy</b>	Any licensed pharmacy that you can physically enter to obtain a prescription drug.
<b>Services</b>	Health care service, procedures, treatments, durable medical equipment, medical supplies and prescription drugs.
<b>Sexual dysfunction</b>	Inadequate enjoyment of or failure to participate in or enjoy sexual activity.



<b>Skilled care</b>	Services rendered other than in a skilled nursing facility that are medically necessary and provided by a licensed nurse or other licensed health care professional. A service shall not be considered skilled care merely because it is performed by, or under the direct supervision of, a licensed nurse. Services such as tracheotomy suctioning or ventilator monitoring that can be safely and effectively performed by a non-medical person (or self-administered) without direct supervision of a licensed nurse, shall not be regarded as skilled care, whether or not a licensed nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it skilled care when a licensed nurse provides the service. Only the skilled care component of combined services that include non-skilled care are covered under the Plan.
<b>Skilled nursing care – extended hours</b>	<p>Extended hours home care (skilled nursing services) are continuous and complex skilled nursing services greater than two (2) consecutive hours per date of service in the member's home.</p> <p>Extended hours skilled nursing care services provide complex, direct, skilled nursing care to develop caregiver competencies through training and education to optimize the member's health status and outcomes. The frequency of the nursing tasks is continuous and temporary in nature and is not intended to be provided on a permanent, ongoing basis.</p>
<b>Skilled nursing care – intermittent hours</b>	Intermittent skilled nursing services consist of up to two (2) consecutive hours per date of service in the member's home provided by a licensed registered nurse or licensed practical nurse who are employees of an approved home health care agency.
<b>Skilled nursing facility</b>	A Medicare approved facility that provides skilled transitional care, by or under the direction of a doctor of medicine (M.D.) or osteopathy (D.O.), after a hospital stay. A skilled nursing facility provides 24-hour-a-day professional registered nursing (R.N.) services.
<b>Specialty Pharmacy Network</b>	A nationwide pharmaceutical specialty provider that participates in a network for the dispensing of certain oral medications and injectable drugs.
<b>Student Health Benefit Plan</b>	The Student Health Benefit Plan of benefits established by the Student Health Benefit Plan Administrator.
<b>Student Health Benefit Plan Administrator</b>	University of Minnesota; Office of Student Health Benefits.
<b>Substance abuse and/or addictions</b>	Alcohol, drug dependence or other addictions as defined in the most current editions of the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual for Mental Disorders (DSM).
<b>Supervised employees</b>	Health care professional employed by a doctor of medicine, osteopathy, chiropractic, or dental surgery or Minnesota Rule 29 behavioral health treatment facilities licensed by the Minnesota Department of Human Services. The employing M.D., D.O., D.C., D.D.S. or mental health professional must be physically present and immediately available in the same office suite more than 50 percent of each day when the employed health care professional is providing services. Independent contractors are not eligible.

<b>Supply</b>	<p>Equipment that must be medically necessary for the medical treatment or diagnosis of an illness or injury or to improve functioning of a malformed body part. Supplies are not reusable, and usually last for less than one (1) year.</p> <p>Supplies do not include such things as:</p> <ol style="list-style-type: none"> <li>1. alcohol swabs;</li> <li>2. cotton balls;</li> <li>3. incontinence liners/pads;</li> <li>4. Q-tips;</li> <li>5. adhesives; or</li> <li>6. informational materials.</li> </ol>
<b>Surrogate pregnancy</b>	An arrangement whereby a woman who is not covered under this Plan becomes pregnant for the purpose of gestating and giving birth to a child for others to raise.
<b>Telemedicine</b>	Telemedicine services may also be referred to as televideo consultations or telehealth services. These services are interactive audio and video communications, permitting real-time communication between a distant site physician or practitioner and the member, who is present and participating in the televideo visit at a remote facility.
<b>Terminally ill patient</b>	An individual who has a life expectancy of six (6) months or less, as certified by the person's primary physician.
<b>Therapeutic camps</b>	A structured recreational program of behavioral health treatment and care provided by an enrolled family community support services provider that is licensed as a day program. The camps are accredited as a camp by the American Camping Association.
<b>Therapeutic day care (pre-school)</b>	A licensed program that provides behavioral health care services to a child who is at least 33 months old but who has not yet attended the first day of kindergarten. The therapeutic components of a pre-school program must be available at least one (1) day a week for a minimum two (2)-hour time block. Services may include individual or group psychotherapy and a combination of the following activities: recreational therapy, socialization therapy and independent living skills therapy.
<b>Therapeutic support of foster care</b>	Behavioral health training, support services, and clinical supervision provided to foster families caring for children with severe emotional disturbance. The intended purpose is to provide a therapeutic family environment and support for the child's improved functioning.
<b>Tobacco cessation drugs and products</b>	Prescription drugs and over-the-counter products that aid in reducing or eliminating the use of nicotine.
<b>Treatment</b>	The management and care of a patient for the purpose of combating an illness. Treatment includes medical care surgical care, diagnostic evaluation, giving medical advice, and monitoring and taking medication.





## **Student Health Benefits**

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