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Summary of Benefits (SB) Effective Date: September 1, 2018 – August 31, 2019

HealthPartners Open Access Choice
Schedule of Benefits

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

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

Coverage may vary according to your network or provider selection.

When you use Out-of-Network Providers, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses. An Out-of-Network Provider does not have an agreement with HealthPartners to provide services at the discounted fee. In addition, most Out-of-Network Benefits are restricted to the usual and customary amount under the definition of “Charge”. If the Out-of-Network Provider’s billed charges are over the usual and customary amount, you pay the difference, in addition to any required deductible, copayment and/or coinsurance, and these charges do not apply to the out-of-pocket limit. The only exceptions to this requirement are described in the Schedule of Payments under the “Emergency and Urgently Needed Care Services” section. These services are covered at the Network Benefit level regardless of who provides the service.

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

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

For covered services delivered by out-of-network providers, a contracted rate may apply if such arrangement is available to the Plan Manager.

For the usual and customary charge for covered services delivered by out-of-network providers, the Plan’s payment is calculated using one of the following options to be determined at the Plan Manager’s discretion: 1) a percentage of the Medicare fee schedule; 2) a comparable schedule if the service is not available on the Medicare fee schedule; or 3) a commercially reasonable rate for such service.

The usual and customary charge is the maximum amount allowed that the Plan considers in the calculation of the payment of charges incurred for certain covered services. You must pay for any charges above the usual and customary charge, and they do not apply to the out-of-pocket limit.

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

**Copayment/Coinsurance:**
The specified dollar amount, or percentage, of charges incurred for covered services, which the Plan does not pay, but which a Covered Person must pay, each time a Covered Person receives certain medical services, procedures or items. The Plan’s payment for those covered services or items begins after the copayment or coinsurance is satisfied. Covered services or items requiring a copayment or coinsurance are specified in this SB.
For services provided by a network provider:
The amount which is listed as a percentage of charges or coinsurance is based on the network providers’ discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule rate for case rate or withhold arrangements. However, if a network providers’ discounted charge for a service or item is less than the flat dollar copayment, you will pay the network providers’ discounted charge. A copayment or coinsurance is due at the time a service is provided, or when billed by the provider.

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

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

**Deductible:**

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

Amounts paid or reimbursed by a third party, including but not limited to: point of service rebates, manufacturer coupons, debit cards or other forms of direct reimbursement to a Covered Person for a product or service, may not apply toward your deductible.

**Out-of-Pocket Expenses:**

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

**Out-of-Pocket Limit:**

You pay the copayments/coinsurance and deductibles for covered services, to the individual or family out-of-pocket limit. Thereafter, 100% of charges incurred are covered under the Plan for all other covered services for the rest of the plan year. You pay amounts greater than the out-of-pocket limit if you exceed any visit or day limits.

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

Amounts paid or reimbursed by a third party, including but not limited to: point of service rebates, manufacturer coupons, debit cards or other forms of direct reimbursement to a Covered Person for a product or service, may not apply as an out-of-pocket expense.

You are responsible to keep track of the out-of-pocket expenses. Contact HealthPartners Member Services department for assistance in determining the amount paid by the Covered Person for specific eligible services received. Claims for reimbursement under the out-of-pocket limit provisions are subject to the same time limits and provisions described under the “Claims Procedures” section of the SB.
<table>
<thead>
<tr>
<th></th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Plan Year Deductible</td>
<td>None.</td>
<td>$200</td>
</tr>
<tr>
<td>Family Plan Year Deductible</td>
<td>None.</td>
<td>$600</td>
</tr>
<tr>
<td>Individual Plan Year Out-of-Pocket Limit for Prescription Drugs</td>
<td>$300 per person.</td>
<td>$300 per person.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Out-of-Pocket Limit for prescription drugs does not include prescription drugs administered during treatment in a hospital, drugs for the treatment of growth deficiency, drugs for the treatment of infertility, special dietary treatment for Phenylketonuria (PKU), injections administered in a doctor’s office, durable medical equipment, diabetic supplies and amino acid based elemental formula. These listed services will apply toward the out-of-pocket limits for all other services, shown below.</td>
</tr>
<tr>
<td>Individual Plan Year Out-of-Pocket Limit for all other services</td>
<td>$2,500 per person.</td>
<td>$2,500 per person.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Out-of-Pocket Limits under the Network Benefits and the Out-of-Network Benefits are combined.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-of-Network Benefits above the usual and customary charge (see definition of charge above) do not apply to the out-of-pocket limit.</td>
</tr>
</tbody>
</table>
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

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

<table>
<thead>
<tr>
<th>A. ACUPUNCTURE</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10 copayment and 100% thereafter per office visit.</td>
<td>No coverage.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. AMBULANCE AND MEDICAL TRANSPORTATION</th>
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</thead>
<tbody>
<tr>
<td>Ambulance and medical transportation (other than non-emergency fixed wing air ambulance transportation)</td>
</tr>
<tr>
<td>Non-emergency fixed wing air ambulance transportation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. BEHAVIORAL HEALTH SERVICES</th>
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</thead>
<tbody>
<tr>
<td>Mental Health Services</td>
</tr>
<tr>
<td>a. Outpatient Services, including group therapy, day treatment and intensive outpatient services</td>
</tr>
<tr>
<td>Facility Fees</td>
</tr>
<tr>
<td>Professional Fees</td>
</tr>
<tr>
<td>Duluth Campus students using UMD Health Services are not required to pay a copayment.</td>
</tr>
<tr>
<td>For family therapy received under the Network Benefits, only one copayment will be charged, regardless of the number of family members primarily involved in the therapy.</td>
</tr>
<tr>
<td>b. Inpatient Services, including psychiatric treatment for emotionally disabled children</td>
</tr>
</tbody>
</table>
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
<thead>
<tr>
<th>Chemical Health Services</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
</table>
| a. Outpatient Services, including day treatment, group therapy and intensive outpatient services | Facility Fees: 100% of the charges incurred. 
Professional Fees: $10 copayment and 100% thereafter per office visit. |
| b. Inpatient Services | 100% of the charges incurred. |

**Network Benefits**

- **Outpatient Services**, including day treatment, group therapy and intensive outpatient services:
  - Facility Fees: $10 copayment and 100% thereafter per office visit.
  - Professional Fees: 100% of the charges incurred.
  
  *For family therapy received under the Network Benefits, only one copayment will be charged, regardless of the number of family members primarily involved in the therapy.*

**Out-of-Network Benefits**

- 100% of the charges incurred.
- Deductible does not apply.

**Network Benefits**

- Inpatient Services: 100% of the charges incurred.
- Deductible must first be satisfied.

**D. CHIROPRACTIC SERVICES**

- $10 copayment and 100% thereafter per office visit.

**E. CLINICAL TRIALS**

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

**F. DENTAL SERVICES**

- Graduate assistants receive preventive and restorative dental coverage through designated clinics contracted with the University of Minnesota. Twin Cities Campus Designated Dental Clinic: Boynton Health Dental Clinic, 612-624-9998. Duluth Campus Designated Dental Clinic: Lake Superior Dental Associates, 218-728-6445. See www.shb.umn.edu for details.

**Accidental Dental Services**

- $10 copayment and 100% thereafter per visit.
- 80% of charges incurred.
- Deductible must first be satisfied.

*For all accidental dental services, treatment and/or restoration must be initiated within 12 months of the date of the injury. Coverage is limited to the initial course of treatment and/or initial restoration. Services must be provided within 24 months of the date of injury to be covered.*
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

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<thead>
<tr>
<th>Medical Referral Dental Services</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Medically Necessary Outpatient Dental Services</td>
<td>$10 copayment and 100% thereafter per visit.</td>
<td>80% of charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>b. Medically Necessary Hospitalization and Anesthesia for Dental Care</td>
<td>100% of the charges incurred.</td>
<td>100% of the charges incurred. Deductible does not apply.</td>
</tr>
<tr>
<td>c. Medical Complications of Dental Care</td>
<td>$10 copayment and 100% thereafter per visit.</td>
<td>80% of charges incurred. Deductible must first be satisfied.</td>
</tr>
</tbody>
</table>

| Oral Surgery | 100% of the charges incurred. | 80% of charges incurred. Deductible must first be satisfied. |

| Special Oral Surgery | 100% of the charges incurred. | 80% of charges incurred. Deductible must first be satisfied. |

| Orthognathic Surgery Benefit | $10 copayment and 100% thereafter per visit. | 80% of charges incurred. Deductible must first be satisfied. |

| Treatment of Cleft Lip and Cleft Palate | $10 copayment and 100% thereafter per visit. | 80% of charges incurred. Deductible must first be satisfied. |

| Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD) | $10 copayment and 100% thereafter per visit. | 80% of charges incurred. Deductible must first be satisfied. |

G. **DIAGNOSTIC IMAGING SERVICES**

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

Associated with covered preventive services (MRI/CT procedures are not considered preventive) 100% of the charges incurred. Diagnostic imaging for preventive services is covered at the benefit level shown in the Preventive Services section.

For illness or injury

a. Outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) 100% of the charges incurred. 80% of the charges incurred. Deductible must first be satisfied. 

b. All other outpatient diagnostic imaging services 100% of the charges incurred. 80% of the charges incurred. Deductible must first be satisfied.
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>H. DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES</td>
<td>80% of the charges incurred.</td>
<td>80% of the charges incurred. Deductible does not apply.</td>
</tr>
<tr>
<td>Special dietary treatment for Phenylketonuria (PKU)</td>
<td>80% of the charges incurred.</td>
<td>80% of the charges incurred. Deductible does not apply.</td>
</tr>
<tr>
<td>Oral amino acid based elemental formula if it meets our medical coverage criteria</td>
<td>80% of the charges incurred.</td>
<td>80% of the charges incurred. Deductible does not apply.</td>
</tr>
</tbody>
</table>

Wigs for hair loss resulting from alopecia areata are limited to one per plan year for Network Benefits and Out-of-Network Benefits combined. No more than a 90-day supply of diabetic supplies will be covered and dispensed at a time.

I. EMERGENCY AND URGENT CARE SERVICES

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convenience clinics</td>
<td>$5 copayment and 100% thereafter per office visit.</td>
<td>80% of charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>Urgent care provided at clinics</td>
<td>$10 copayment and 100% thereafter per office visit.</td>
<td>80% of charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>Emergency care in a hospital emergency room, including professional services of a physician</td>
<td>$40 copayment and 100% thereafter per emergency room visit.</td>
<td>See Network Benefits.</td>
</tr>
</tbody>
</table>

Emergency room copayment is waived if admitted for the same condition within 24 hours.

Inpatient emergency care in a hospital

| Facility Fees                                                                      | 100% of the charges incurred.       | 100% of the charges incurred. Deductible does not apply. |
| Professional Fees                                                                  | 100% of the charges incurred.       | 80% of charges incurred. Deductible must first be satisfied. |

Out-of-Network professional fees will be paid at the Network Inpatient Hospital Services Benefit level if the Covered Person is admitted inpatient to a network hospital through the emergency room.

J. HEALTH EDUCATION

<table>
<thead>
<tr>
<th>Health Education Service</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$10 copayment and 100% thereafter per office visit.</td>
<td>80% of charges incurred. Deductible must first be satisfied.</td>
</tr>
</tbody>
</table>

K. HEARING AID BENEFIT

<table>
<thead>
<tr>
<th>Hearing Aid Benefit Service</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80% of the charges incurred.</td>
<td>80% of charges incurred. Deductible must first be satisfied.</td>
</tr>
</tbody>
</table>

Limited to one hearing aid for each ear every three years for the Network Benefits and Out-of-Network Benefits combined.
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
<thead>
<tr>
<th>L. HOME HEALTH SERVICES</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical therapy, occupational therapy, speech therapy, respiratory therapy, home health aide services and palliative care</td>
<td>100% of the charges incurred.</td>
<td>100% of the charges incurred. Deductible does not apply.</td>
</tr>
<tr>
<td>TPN/IV therapy, skilled nursing services, non-routine prenatal/postnatal services, and phototherapy</td>
<td>100% of the charges incurred.</td>
<td>100% of the charges incurred. Deductible does not apply.</td>
</tr>
</tbody>
</table>

Each 24-hour visit (or shifts of up to 24-hour visits) equals one visit and counts toward the maximum visits for all other services shown below. Any visit that lasts less than 24 hours, regardless of the length of the visit, will count as one visit toward the maximum visits for all other services shown below. All visits must be medically necessary and benefit eligible.

If you are eligible to receive palliative care in the home and you are not homebound, there is a maximum of 12 visits per plan year.

For all other services that meet the home health services requirements described in this SB, there is a maximum of 120 visits per plan year.

Routine prenatal/postnatal services and child health supervision services | 100% of the charges incurred. | 100% of the charges incurred. Deductible does not apply. |

The routine prenatal/postnatal services and child health supervision services visits do not count toward the visit limits above.

M. HOME HOSPICE SERVICES

100% of the charges incurred. No coverage.

Respite care is limited to five days per episode, and respite care and continuous care combined are limited to 30 days.
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

### N. HOSPITAL AND SKILLED NURSING FACILITY SERVICES

#### Medical or Surgical Hospital Services

##### a. Inpatient Hospital Services

<table>
<thead>
<tr>
<th></th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Fees</td>
<td>100% of the charges incurred.</td>
<td>Deductible does not apply.</td>
</tr>
<tr>
<td>Professional Fees</td>
<td>100% of the charges incurred.</td>
<td>80% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
</tbody>
</table>

Each Covered Person’s admission or confinement, including that of a newborn child, is separate and distinct from the admission or confinement of any other Covered Person.

##### b. Outpatient Hospital, Ambulatory Care or Surgical Facility Services

*to see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see the benefits under Diagnostic Imaging Services, Laboratory Services and Physical Therapy*

<table>
<thead>
<tr>
<th></th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Fees</td>
<td>100% of the charges incurred.</td>
<td>Deductible does not apply.</td>
</tr>
<tr>
<td>Professional Fees</td>
<td>100% of the charges incurred.</td>
<td>80% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
</tbody>
</table>

#### Skilled Nursing Facility Care

<table>
<thead>
<tr>
<th></th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Fees</td>
<td>100% of the charges incurred.</td>
<td>Deductible does not apply.</td>
</tr>
<tr>
<td>Professional Fees</td>
<td>100% of the charges incurred.</td>
<td>80% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
</tbody>
</table>

Limited to 120-day maximum per period of confinement.

Each day of services provided under the Network Benefits and Out-of-Network Benefits, combined, counts toward the maximums shown above.

### O. INFERTILITY SERVICES

*Includes injections for the treatment of Infertility received in a physician’s office.*

<table>
<thead>
<tr>
<th></th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$10 copayment and 100% thereafter per office visit.</td>
<td>80% of charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>Duluth Campus students using UMD Health Services are not required to pay a copayment.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Artificial insemination for Covered Persons diagnosed with infertility is limited to six cycles per confirmed pregnancy.
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P. LABORATORY SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td><em>The Plan covers services provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)</em></td>
<td></td>
</tr>
<tr>
<td>100% of the charges incurred.</td>
<td>Laboratory for preventive services is covered at the benefit level shown in the Preventive Services section.</td>
</tr>
<tr>
<td><strong>Q. MASTECTOMY RECONSTRUCTION BENEFIT</strong></td>
<td></td>
</tr>
<tr>
<td>Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.</td>
<td>Coverage level is same as corresponding Out-of-Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.</td>
</tr>
<tr>
<td><strong>R. OFFICE VISITS FOR ILLNESS OR INJURY</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Office Visits</strong></td>
<td></td>
</tr>
<tr>
<td>$10 copayment and 100% thereafter per office visit. Duluth Campus students using UMD Health Services are not required to pay a copayment.</td>
<td>80% of charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>Injections administered in a physician’s office</td>
<td></td>
</tr>
<tr>
<td><strong>Allergy injections</strong></td>
<td></td>
</tr>
<tr>
<td>100% of the charges incurred.</td>
<td>80% of charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td><strong>All other injections</strong></td>
<td></td>
</tr>
<tr>
<td>100% of the charges incurred.</td>
<td>80% of charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td><strong>Convenience clinics (Includes access to Online Care through virtuwell at <a href="http://www.virtuwell.com">www.virtuwell.com</a>)</strong></td>
<td></td>
</tr>
<tr>
<td>$5 copayment and 100% thereafter per office visit.</td>
<td>80% of charges incurred. Deductible must first be satisfied.</td>
</tr>
</tbody>
</table>
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S. PEDIATRIC DENTAL SERVICES</strong>&lt;br&gt;for Covered Persons up to age 19&lt;br&gt;<em>Pediatric Dental Services are exclusively provided coverage through designated clinics contracted with the University of Minnesota. Twin Cities Campus Designated Dental Clinic: Boynton Health Dental Clinic, 612-624-9998.</em>&lt;br&gt;Designated Dental Clinic: Lake Superior Dental Associates, 218-728-6445. See <a href="http://www.shb.umn.edu">www.shb.umn.edu</a> for details.</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Services, Preventive Care and Periodontics</strong></td>
<td>100% of the charges incurred.</td>
</tr>
<tr>
<td><strong>Basic Services</strong> (Fillings, Endodontics and Oral Surgery)</td>
<td>80% of the charges incurred.</td>
</tr>
<tr>
<td><strong>Medically Necessary Orthodontic Services</strong></td>
<td>50% of the charges incurred.</td>
</tr>
<tr>
<td><strong>Major Services</strong> (Crowns, Dentures and Bridges)</td>
<td>50% of the charges incurred.</td>
</tr>
<tr>
<td><strong>T. PEDIATRIC EYEWEAR</strong>&lt;br&gt;for covered dependents up to age 19&lt;br&gt;(See Preventive Services for coverage for routine eye exams)</td>
<td>100% of the charges incurred.</td>
</tr>
<tr>
<td>No coverage.</td>
<td></td>
</tr>
</tbody>
</table>

*Corrective lenses for children up to age 19. See Section III. “Description of Covered Services”, item S. “Pediatric Eyewear”, for more information on what is covered.*

*Limited to one pair of eyeglasses (lenses and frames) per plan year or, if medically necessary, one pair of contact lenses per plan year (including lens fitting and exam).*
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
</table>
| **U. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY**  
The Plan covers services provided in a clinic. The Plan also covers physical therapy provided in an outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services) |  |
|  
| Rehabilitative therapy | $10 copayment and 100% thereafter per visit. | 80% of charges incurred.  
Deductible must first be satisfied. |
|  
| Habilitative therapy | $10 copayment and 100% thereafter per visit. | 80% of charges incurred.  
Deductible must first be satisfied. |
| **V. PRESCRIPTION DRUG SERVICES**  
Drugs and medications must be obtained at a network pharmacy |  |
|  
| Outpatient Drugs (except as specified below) | $10 copayment and 100% thereafter per prescription for generic formulary drugs. | 80% of the charges incurred.  
Deductible must first be satisfied. |
| If there is a generic equivalent, brand name drugs are only covered up to the charge that would apply to the generic drug, minus any required copayment, regardless of a Physician’s Prior Approval request. The brand name drug will not be covered as a non-formulary drug unless a Physician requests that the drug be dispensed as written and HealthPartners approves the request. |  
|  
| $25 copayment and 100% thereafter per prescription for brand name formulary drugs. |  
|  
| $50 copayment and 100% thereafter per prescription for non-formulary drugs. |  
|  
| Contraceptives are covered at 100% of the charges incurred. |  
| Drugs for breast cancer prevention are covered at 100% of the charges incurred for women at high risk for breast cancer who have not yet been diagnosed with the disease. |  
|  
| *Drugs for the treatment of sexual dysfunction are limited to six doses per month.* |  
|  
| Tobacco cessation products, as determined by HealthPartners. Must be prescribed by a licensed provider. |  
|  
| 100% of the charges incurred. | 80% of the charges incurred.  
Deductible must first be satisfied. |
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mail Order Drugs</strong></td>
<td>Mail order drugs are only available through HealthPartners mail order service. See Network Benefits.</td>
</tr>
<tr>
<td>You may also get outpatient prescription drugs which can be self-administered through HealthPartners mail order service. Drugs ordered through this service are covered at the benefit percent shown in Outpatient Drugs above, subject to two copayments for each 90-day supply or portion thereof.</td>
<td></td>
</tr>
<tr>
<td>Drs for the treatment of sexual dysfunction are limited to 18 doses per 90-day supply.</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs are not available through the mail order service.</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetic Supplies purchased at a pharmacy</strong></td>
<td></td>
</tr>
<tr>
<td>$10 copayment and 100% thereafter per prescription for generic formulary drugs.</td>
<td>80% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>$25 copayment and 100% thereafter per prescription for brand name formulary drugs.</td>
<td></td>
</tr>
<tr>
<td>$50 copayment and 100% thereafter per prescription for non-formulary drugs.</td>
<td></td>
</tr>
<tr>
<td><strong>Drugs for treatment of infertility</strong></td>
<td>80% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>$10 copayment and 100% thereafter per prescription for generic formulary drugs.</td>
<td></td>
</tr>
<tr>
<td>$25 copayment and 100% thereafter per prescription for brand name formulary drugs.</td>
<td></td>
</tr>
<tr>
<td>$50 copayment and 100% thereafter per prescription for non-formulary drugs.</td>
<td></td>
</tr>
<tr>
<td>Infertility drugs must be obtained from a designated vendor.</td>
<td></td>
</tr>
<tr>
<td><strong>Specialty drugs which are self-administered</strong></td>
<td></td>
</tr>
<tr>
<td>$10 copayment and 100% thereafter per prescription for generic formulary drugs.</td>
<td>80% of the charges incurred. Deductible must first be satisfied.</td>
</tr>
<tr>
<td>$25 copayment and 100% thereafter per prescription for brand name formulary drugs.</td>
<td></td>
</tr>
<tr>
<td>$50 copayment and 100% thereafter per prescription for non-formulary drugs.</td>
<td></td>
</tr>
</tbody>
</table>
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs for the treatment of growth deficiency</td>
<td>80% of the charges incurred.</td>
<td>80% of the charges incurred.</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs are limited to drugs on the specialty drug list, and must be obtained from a designated vendor.</td>
<td>80% of the charges incurred.</td>
</tr>
<tr>
<td></td>
<td>Deductible must first be satisfied.</td>
<td></td>
</tr>
</tbody>
</table>

Unless otherwise specified above in the Prescription Drug Services section, you may receive up to a 34-day supply per prescription. All drugs are subject to HealthPartners utilization review process and quantity limits. New prescriptions to treat certain chronic conditions are limited to a 34-day supply. In addition, certain drugs may be subject to any quantity limits applied as part of the trial program. The trial drug program applies to new prescriptions for certain drugs which have high toxicity, low tolerance, high costs and/or high potential for waste. Trial drugs are indicated on the formulary and/or the specialty drug list. Your first fill of a trial drug may be limited to less than a month supply. If the drug is well tolerated and effective, you will receive the remainder of your first month supply. Certain non-formulary drugs require prior authorization. A 90-day supply will be covered and dispensed at a time only at pharmacies that participate in the HealthPartners extended day supply program. No more than a 34-day supply of specialty drugs will be covered and dispensed at a time, unless it’s a manufacturer supplied drug that cannot be split that supplies the Covered Person with more than a 34-day supply.

Drugs on the Excluded Drug List are not covered. The Excluded Drug List includes select drugs within a therapy class that are not eligible for coverage. You can find the Excluded Drug List if you go to healthpartners.com, select Pharmacy and select any of the formularies.

If you request a brand name drug when there is a generic equivalent, the brand name drug will be covered up to the charge that would apply to the generic drug, minus any required copayment, regardless of a Physician’s Prior Approval request. If a physician requests that a brand name drug be dispensed as written (DAW), the drug will not be paid at the non-formulary benefit unless HealthPartners approves the request.

If a copayment is required, you must pay one copayment for each 34-day supply or portion thereof, except for mail order drugs, see benefit above.

Prescription drugs are subject to the plan year out-of-pocket limit shown above.

W. PREVENTIVE SERVICES

1. Routine health exams and periodic health assessments
   - 100% of the charges incurred. 80% of charges incurred. Deductible must first be satisfied.

2. Child health supervision services
   - 100% of the charges incurred. 100% of the charges incurred. Deductible does not apply.

3. Routine prenatal care
   - 100% of the charges incurred. 100% of the charges incurred. Deductible does not apply.

4. Routine postnatal care
   - 100% of the charges incurred. 100% of the charges incurred. Deductible does not apply.

5. Routine screening procedures for cancer
   - 100% of the charges incurred. 80% of charges incurred. Deductible must first be satisfied.

6. Routine eye and hearing exams
   - 100% of the charges incurred. 80% of charges incurred. Deductible must first be satisfied.

7. Professional voluntary family planning services
   - 100% of the charges incurred. 80% of charges incurred. Deductible must first be satisfied.
COVERED SERVICES. See Sections III. and IV. of this SB for additional information about covered services and limitations.

<table>
<thead>
<tr>
<th>8. Adult immunizations</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% of the charges incurred.</td>
<td>80% of charges incurred.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible must first be satisfied.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. Women’s preventive health services including all FDA approved contraceptive methods as prescribed by a physician (see prescription drug services section for coverage of contraceptive drugs)</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% of the charges incurred.</td>
<td>80% of charges incurred.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible must first be satisfied.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. Obesity screening and management</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% of the charges incurred.</td>
<td>80% of charges incurred.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible must first be satisfied.</td>
</tr>
</tbody>
</table>

X. SPECIFIED OUT-OF-NETWORK SERVICES

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

See Network Benefits for the services covered.

Y. TELEMEDICINE BENEFIT

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

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

Z. TRANSPLANT SERVICES

<table>
<thead>
<tr>
<th>Facility Fees</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% of the charges incurred.</td>
<td>100% of the charges incurred.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional Fees</th>
<th>Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% of the charges incurred.</td>
<td>80% of charges incurred.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible must first be satisfied.</td>
</tr>
</tbody>
</table>

AA. WEIGHT LOSS SURGERY OR BARIATRIC SURGERY

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

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

Enrollment and Eligibility Questions
Office of Student Health Benefits
410 Church Street S.E., Room N323
Minneapolis, MN 55455
Phone: 612-624-0627 or 800-232-9017 (toll-free)
Fax: 612-626-5183 or 800-624-9881 (toll-free)
E-mail: umshbo@umn.edu
www.shb.umn.edu

Coverage, Network, and Claims Questions
HealthPartners Member Services
Phone: 952-883-7500 or 866-270-5434 (toll-free)
www.healthpartners.com/uofmga

On-Campus Health Care Questions
Boynton Health
(Twin Cities Campus Students)
410 Church Street S.E.
Minneapolis, MN 55455
Phone: 612-625-8400
E-mail: bh-quest@umn.edu
www.boynton.umn.edu

Dental Questions
(Twin Cities Campus Students)
Boynton Health Dental Clinic
410 Church Street S.E.
Minneapolis, MN 55455
Phone: 612-624-9998
www.boynton.umn.edu/clinics/dental-clinic

On-Campus Health Care Questions
UMD Health Services
(Duluth Campus Students)
615 Niagara Court
Duluth, MN 55812
Phone: 218-726-8155
www.d.umn.edu/health-services

Dental Questions
(Duluth Campus Students)
Lake Superior Dental Associates
1225 East First Street
Duluth, MN 55805
Phone: 218-728-6445
www.lakesuperiordental.com

Emergency Travel Assistance Questions
See www.shb.umn.edu for contact information
SPECIFIC INFORMATION ABOUT THE PLAN

Name of the Plan: The Plan shall be known as the University of Minnesota Graduate Assistant Health Plan which provides student and dependent medical benefits

Address of the Plan: 410 Church Street S.E., Room N323
Minneapolis, MN 55455
612-624-0627

Group Number: 24000

Plan Year: The period beginning on each September 1 in which the provisions of the Plan are in effect.

Plan Fiscal Year Ends: December 31

Plan Sponsor: University of Minnesota
(is ultimately responsible for the management of the Plan; may employ or contract with persons or firms to perform day-to-day functions such as processing claims and performing other Plan-connected services.)

Agent for Service of Legal Process: General Counsel for University of Minnesota

Named Fiduciary: For purposes of determining eligibility and enrollment, and for funding claims paid and all related activities and responsibilities under the Plan, University of Minnesota is the named fiduciary.

Solely for purposes of determining coverage of claims, HealthPartners Administrators, Inc. is the named fiduciary.

Funding: Claims under the Plan are paid from the general assets of the Plan Sponsor.

Plan Manager: HealthPartners Administrators, Inc.
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
952-883-6000

Network Providers: Open Access Network

Contributions: Please refer to the most recent enrollment material for information regarding contributions to your Plan which is hereby incorporated by this reference.
HEALTHPARTNERS MISSION

OUR MISSION IS TO IMPROVE HEALTH AND WELL-BEING IN PARTNERSHIP WITH OUR MEMBERS, PATIENTS AND COMMUNITY.

ABOUT HEALTHPARTNERS and the PLAN SPONSOR

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

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

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

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

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

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

The Graduate Assistant Health 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 Graduate Assistant Health 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.

The Graduate Assistant Health Plan is not subject to the Covered Person Retirement Income Security Act of 1974 (ERISA).

HealthPartners Trademarks. HealthPartners names and logos and all related products and service names, design marks and slogans are the trademarks of HealthPartners or its related companies.

Where applicable to pediatric dental services, any references in the Plan to medical care, treatment, service, and supplies are expanded to include dental care, treatment, services and supplies, to the extent that they are described in this SB.

Where applicable to pediatric dental services, any references in the Plan to network providers include dentists, and any references to network clinics include designated clinics contracted with the University of Minnesota.
I. INTRODUCTION TO THE SUMMARY OF BENEFITS

A. SUMMARY OF BENEFITS (“SB”)

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

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

The Plan is maintained exclusively for Covered Students and their Covered Dependents. Each Covered Person's rights under the Plan are legally enforceable. You may not, in any way, assign or transfer your rights or benefits under the Plan. In addition, you may not, in any way, assign or transfer your right to pursue any causes of action arising under the Plan including, but not limited to, causes of action for denial of benefits under the Plan.

B. MEDICAL ADMINISTRATIVE SERVICES AGREEMENT (“ASA”)

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

C. CONFLICT WITH EXISTING LAW

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

D. IDENTIFICATION CARD

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

E. HOW TO USE THE NETWORK

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

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

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

To see what physicians and other health care providers are in your network, log onto your “myHealthPartners” account at www.healthpartners.com or create one at www.healthpartners.com. If you need assistance locating a physician or other health care providers in your network, please contact Member Services.

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

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

Network. This is the network of participating network providers.

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

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

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

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

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

Your physician may be required to obtain prior authorization for certain services. Your physician will coordinate the authorization process for any services which must first be authorized. You may call the Member Services Department or check online at www.healthpartners.com/uofmga for a list of which services require your physician to obtain prior authorization.

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

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

You must use a designated convenience care clinic to obtain the convenience care benefit. Call Member Services or visit www.healthpartners.com/uofmga for a current list.

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

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

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

Multidisciplinary pain management must be provided at designated facilities.

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

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

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

Second Opinions for Network Services. If you question a decision or recommendation about medical care, the Plan covers a second opinion from an appropriate network provider.
Prescription Drugs and Medical Equipment. Enrolling in the Plan does not guarantee that any particular prescription drug will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment was available previously.

F. CARECHECK®

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

1. CARECHECK® Services. CareCheck® is HealthPartners’ utilization review program for out-of-network services. CareCheck® must pre-certify all inpatient confinement and same-day surgery, new, experimental or reconstructive outpatient technologies or procedures, durable medical equipment or prosthetics costing over $3,000, home health services after your visits exceed 30 and skilled nursing facility stays.

2. Procedure to Follow to Receive Maximum Benefits

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

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

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

4. Information Needed When You Call CareCheck®.

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

5. Pre-certification Process.

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

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

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

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

1. ELIGIBILITY. Graduate assistants, trainees, and fellows meeting any of the following conditions are eligible to participate in the Plan. You must be properly registered for the number of credits required for your job class or appointment.

   1. Graduate assistants with appointments of 195 hours or more (65 hours for summer term) per payroll semester in class titles 9510 (Graduate Assistant Coach), 9511 (Teaching Assistant), 9515 (Graduate Instructor), 9517 (Ph.D. Cand. Graduate Instructor), 9518 (Advance Masters TA), 9519 (Ph.D. Cand. W/24 thesis cred. TA), 9521 (Research Assistant), 9526 (Graduate Research Project Assistant), 9527 (Ph.D. Cand. Grad Research Proj. Asst.), 9528 (Advance Masters RA), 9529 (Ph.D. Cand. W/24 thesis cred. RA), 9531 (Administrative fellow), 9532 (Advance Masters Admin. Fellow), 9533 (PHD. Cand. W/24 thesis cred. AF), 9535 (Professional Program Asst.), 9571 (Summer Term TA), 9572 (Summer Term RA), 9573 (Summer Term AF), 9574 (summer Session TA w/T. Ben.), 9575 (Summer Session TA w/o T. Ben).

   2. Trainees or fellows with appointments in class titles, 9560 (Post-Doctoral Fellow), 9561 (Graduate School Fellow), 9562 (Graduate School Trainee), 9564 (Professional School Fellow), or 9565 (Professional School Trainee), 9566 (Graduate Fellow), who receive a stipend during the academic year equivalent to at least a 25% nine month graduate assistantship and whose departments agree to pay the full departmental cost of coverage during the academic year.

   3. Graduate assistants holding hourly appointments in an eligible class title of 195 hours or more per semester (65 hours in summer), as estimated by their departments, are eligible for the Plan.

   4. Where a graduate assistant has more than one GA appointment, the appointments are combined to determine eligibility.

   5. Summer Contribution: The University will contribute to the summer premium for graduate assistants who were enrolled in the plan spring semester. Please see detailed information below.

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

Summer Coverage. Graduate assistants enrolled in the plan spring semester automatically remain enrolled for the summer unless they fill out a Cancellation of Coverage form. The deadline to submit this form is May 31. Cancellation requests made after the deadline will be effective the end of the month in which the request is received. For example, a cancellation request received by the Office of Student Health Benefits on June 2 will be processed with a cancellation date of June 31. These students receive a University contribution toward the summer coverage based on the semesters during the academic year in which they held a qualifying graduate assistantship. The sum of appointment percentages for the two academic semesters is divided by two to give an average academic year appointment percentage; the University’s contribution towards your summer premium equals 1.9 times this figure. For example, a student enrolled in the plan both semesters with GA appointments of 25% fall, 50% spring, has an average appointment percentage of 37.5%, and receives a University contribution toward the summer premium of 1.9 times this figure, or 71%. Students who continue to hold an eligible position during the summer term will have that percentage added to the Fall/Spring benefit calculation of the University contribution. Students will be billed for their portion of the cost of the plan on their Student account.

See the definition of Eligible Dependents under section II. Definitions of Terms Used.

Loss of Eligibility & Cancellation of Coverage. Once enrolled in the Plan, you remain a member until you lose eligibility (for example: your appointment drops below 25%, you leave your appointment, your appointment, fellowship or traineeship ends, or you graduate) or you cancel your insurance. Coverage under the plan ends on the last day of the month in which you lose eligibility for the plan as long as you have worked
the required number of hours to meet semester eligibility. For example, a student whose appointment ends March 15 and has met the 195 hour semester requirement is covered under the plan until March 31. Students losing eligibility due to graduation will remain on the plan through the last day of the month in which they graduate regardless of the number of hours worked. In this case the hiring department must notify the Office of Student Health Benefits of the graduation date. Benefits are available thereafter only if the student chooses to continue coverage at their own expense. Contact the Office of Student Health Benefits for deadline information. Students enrolled in the plan spring semester automatically remain enrolled for the summer regardless of loss of eligibility.

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

**Enrollment Deadline.** Enrollment deadlines, other than the open enrollment period, are based on the starting date of your appointment, fellowship, or traineeship (as certified by the hiring department). The enrollment form must be received at the Office of Student Health Benefits within 14 days of your appointment starting date. Students enrolled in the Graduate Assistant Health Plan for spring semester will automatically remain enrolled for summer unless you fill out a Change or Cancellation Form. The deadline to submit the form is May 31.

**Annual Open Enrollment and Dependent Eligibility.** 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 graduate assistant is initially eligible, 2) within 31 days of involuntary loss of other coverage, 3) within 31 days of marriage, birth or adoption, 4) during the open enrollment period (the first 31 days of coverage during the subsequent Fall Semester).

**Failure to enroll a newborn child within 31 days of birth will result in nonpayment of the child’s medical expenses from the moment of birth onward.** Newborns are not automatically covered under the mother’s insurance.

**Choosing a Dependent Plan:** Once you choose dependent plan 1 or 2, you cannot change the plan option selected until the next open enrollment period.

**Dependent child:** birth through age 25 (up to the 26th birthday). An eligible child can include your unmarried or married biological child, legally adopted child or child placed for the purposes of adoption, foster child, stepchild, or any other child state or federal law requires must be treated as a dependent.

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.

**Adding spouse and/or stepchildren**
1. If the Graduate Assistant Health 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.
2. If the Graduate Assistant Health 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).
Adding newborns and children placed for adoption

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

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

The Covered Student must contact the Office of Student Health Benefits and enroll the newborn within 31 days of the child’s birth for coverage to be effective from the moment of birth.

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

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.

Dependent eligibility expires concurrently with that of the Covered Student, unless continuation is elected as described in section VII.A.

Adding disabled children or disabled dependents

A disabled dependent may be added to the Graduate Assistant Health Plan if the disabled dependent is otherwise eligible under the Plan. Coverage starts the first of the month following the day the Graduate Assistant Health 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 Graduate Assistant Health Plan Administrator receives the application within 31 days of the date of eligibility, coverage for your disabled dependent starts on the date of eligibility.

2. If the Graduate Assistant Health 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).

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

4. LATE ENROLLMENT. For eligible students applying after the enrollment deadline, you may enroll yourself at any time. Coverage will be effective from the date the application is received and processed by the Office of Student Health Benefits. Dependents may only enroll during the open enrollment period (section I.G.2.) or if your dependents have met the criteria under “SPECIAL ENROLLMENT PERIOD” below.

5. SPECIAL ENROLLMENT PERIOD. A student who is eligible, but not enrolled for coverage under the Plan, or a dependent of such student if the dependent is eligible but not enrolled for coverage under the Plan, may enroll for coverage under the terms of the Plan if all of the following conditions are met:

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

   c. the student’s or dependent’s coverage described in a. above was:
      
      (1) under a COBRA continuation provision and the coverage under such provision was exhausted; or
      
      (2) not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including: as a result of legal separation; divorce; death; termination of employment; cessation of dependent status; reduction in the number of hours of employment; a situation in which the individual incurs a claim that would meet or exceed a lifetime limit on all benefits; a situation in which coverage is no longer offered to a class of similarly situated individuals that includes the individual; a situation in which an individual loses coverage
through a health maintenance organization or other arrangement because that individual no longer resides, lives or works in the health maintenance organization’s service area or a situation in which the individual’s benefit option is terminated) or employer contributions toward such coverage were terminated; and
d. the student requested such enrollment not later than 31 days after the date of exhaustion of coverage described in c. (1) above, or one of the events listed in c. (2) above.

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

a. the date dependent coverage is made available; or
b. the date of the marriage, birth, or adoption or placement for adoption described in (c) in the paragraph above.

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

a. in the case of marriage, the date of marriage;
b. in the case of a dependent’s birth, as of the date of such birth; or
c. in the case of a dependent’s adoption or placement for adoption, the date of such adoption or placement for adoption.

6. SPECIAL RULES RELATING TO MEDICAID AND CHIP

In general – a student who is eligible but not enrolled for coverage under the terms of the Plan (or a dependent of such a student if the dependent is eligible but not enrolled for coverage under such terms) may enroll for coverage under the terms of the Plan if either of the following conditions is met:

a. TERMINATION OF MEDICAID OR CHIP COVERAGE – the student or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a state child health plan under title XXI of such Act and coverage of the student or dependent under such plan is terminated as a result of loss of eligibility for such coverage and the student requests coverage under the Plan not later than 60 days after the date; or
b. ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHIP – the student or dependent becomes eligible for assistance, with respect to coverage under the Plan, under such Medicaid plan or state child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the student requests coverage under the Plan not later than 60 days after the date the student or dependent is determined to be eligible for such assistance.

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

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

a. The contribution for coverage under the Plan is not made by the due date.
b. When a Covered Student ceases to be eligible under the terms of this Plan, coverage for the student and all Covered Dependents terminates on the last day of the month in which the student’s eligibility ceases, unless continuation is elected as described in section VII.
c. When a Covered Dependent no longer meets this Plan’s definition of Eligible Dependent, coverage for that dependent terminates on the last day of the month in which the dependent’s eligibility ceases, unless continuation is elected as described in section VII.

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

e. When the Plan terminates.

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

g. The date charges are incurred that result in payment up to the lifetime maximum.

To the extent that a termination would be considered a rescission under federal law under terms b., c. and f. above, the Plan Sponsor is required to give the Covered Person 30 days advance notice of termination.

H. PRIVACY OF PROTECTED HEALTH INFORMATION

University of Minnesota Graduate Assistant Health Plan

NOTICE OF PRIVACY PRACTICES

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

Please share this Notice with your covered spouse, as well as any other covered dependents. This Notice also applies to their medical information.

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

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

2. **Your Protected Health Information**

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

3. **How the Health Plan Uses and Discloses your PHI**

   The Health Plan may use and disclose your PHI:

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

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

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

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

- **To the Health Plan Components within the Health Plan** in order to facilitate claims payment and certain health care operations of the other plans.

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

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

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

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

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

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

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

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

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

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

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

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

- **For Specialized Government Functions** such as national security and intelligence activities, protective services for the President of the United States and others, and military and veteran activities (if you are a member of the Armed Forces). If you are an inmate at a correctional institution, we may use or disclose your PHI to provide health care to you or to protect your health and safety or that of others or the security of the correctional institution.

- **For Workers’ Compensation** as authorized by, or to the extent necessary to comply with, state workers’ compensation laws that govern job-related injuries or illness.

The Health Plan will not use or disclose your PHI without your written authorization:
- **For marketing purposes**, unless the marketing is in the form of a face-to-face interaction with you (such as at a University health and benefits fair) or involves providing you with a gift of nominal value (such as mailing you a calendar highlighting certain dates related to your Wellness Program or health plan coverage).

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

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

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

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

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

- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Submit your request in writing by mail or email using the information listed in the Contact Information section of this Notice.
5. 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.

6. The Health Plan’s Duties Concerning your PHI

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

7. 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
www.shb.umn.edu

Effective Date of this Notice:  September 23, 2013

II. DEFINITIONS OF TERMS USED

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

Biosimilar Drugs. A prescription drug, approved by the Food and Drug Administration (FDA), that the FDA has determined is biosimilar to and interchangeable with a biological brand name drug. Biosimilar drugs are not considered generic drugs and are not covered under the generic drug benefit.

Brand Name Drug. A prescription drug approved by the Food and Drug Administration (FDA), that is manufactured, sold, or licensed for sale under a trademark by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired. A few brand name drugs may be covered at the generic drug benefit level if this is indicated on the formulary.

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

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

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

Consultations. These are diagnostic services provided by a dentist or dental specialist other than the practitioner who is providing treatment.

Convenience Clinic. This is a clinic that offers a limited set of services and does not require an appointment.
Cosmetic Care. These are dental services to improve appearance, without treatment of a related illness or injury.

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

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

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

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

Customary Restorative Materials. These are amalgam (silver fillings), glass ionomer and intraorally cured acrylic resin and resin-based composite materials (white fillings).

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

Date of Service. This is generally the date the dental service is performed. For prosthetic or other special restorative procedures, the date of service is the date impressions were made for final working models. For endodontic procedures, date of service is the date on which the root canal was first entered for the purpose of canal preparation.

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

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

Elective Procedures. These are procedures which are available to patients but which are not dentally necessary.

Eligible Dependents. These are the persons shown below. Under the Plan, a person who is considered a Covered Student is not qualified as an eligible dependent. A person who is no longer an eligible dependent (as defined below) on a Covered Student’s Plan may qualify for continuation of coverage within the group as provided in section VII. of this SB.

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

1. **Spouse.** This is a Covered Student’s current legal spouse. If more than one spouse is covered as a student under the Plan, only one spouse shall be considered to have any eligible dependents.

2. **Child.** This is a Covered Student’s (a) natural or legally adopted child (effective from the date of adoption or the date placed for adoption, whichever is earlier); (b) child for whom the Covered Student or the Covered Student’s spouse is the legal guardian; (c) step-child of the Covered Student (that is, the child of the Covered Student’s spouse); or (d) a child covered under a valid qualified medical child support order (as the term is defined by applicable law) which is enforceable against a Covered Person.* In each case the child must be either under 26 years of age or a disabled dependent, as described below. Coverage will terminate the end of the month in which the child turns age 26.

3. **Disabled Dependent.** This is a Covered Student’s dependent as referred to in 2. above, who is beyond the limiting age and is physically or mentally disabled, and dependent on the Covered Student for the majority of his/her financial support. The disability must have come into existence prior to the attainment of the limiting age as described in 2. above. Disability does not include pregnancy. “Disabled” means incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability. The Covered Student must give the Plan Manager a written request for coverage of a disabled dependent. The request must

* A description of the procedures governing qualified medical child support order determinations can be obtained by participants and beneficiaries, without charge, from the Plan Sponsor.
include written proof of disability and must be approved by the Plan Manager, in writing. The Plan Manager must receive the request within 31 days of the date an already enrolled dependent becomes eligible for coverage under this definition, or when adding a new disabled dependent eligible under this definition. The Plan Manager reserves the right to periodically review disability, provided that after the first two years, the Plan Manager will not review the disability more frequently than once every 12 months.

**Emergency Accidental Dental Services.** These are services required immediately, because of a dental accident.

**Endodontics.** This is the treatment of diseases of the dental pulp. Endodontics includes root canal therapy, pulp capping procedures, apexification and periapical procedures associated with root canal treatment.

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

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

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

**Formulary.** This is a current list, which may be revised from time to time, of formulary prescription drugs, medications, equipment and supplies covered under the Plan as indicated in the Schedule of Benefits which are covered at the highest benefit level. Some drugs may require prior authorization to be covered as formulary drugs. The formulary drug list, and information on drugs that require prior authorization, are available online at www.healthpartners.com/uofmga or by calling Member Services.

**Generic Drug.** A prescription drug, approved by the Food and Drug Administration (FDA), that the FDA has determined is comparable to a brand name drug product in dosage form, strength, route of administration, quality, intended use and documented bioequivalence. Generally, generic drugs cost less than brand name drugs. Some brand name drugs may be covered at the generic drug benefit level if this is indicated on the formulary.

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

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

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

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

**Inpatient.** This is a medically necessary confinement for acute care of illness or injury, other than in a hospital’s outpatient department, where a charge for room and board is made by the hospital or skilled nursing facility. The Plan covers a semi-private room, unless a physician recommends that a private room is medically necessary. In the event a Covered Person chooses to receive care in a private room under circumstances in which it is not medically necessary, payment under the Plan toward the cost of the room shall be based on the average semi-private room rate in that facility.
Investigative. As determined by HealthPartners, a drug, device or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness or effect on health outcomes. The following categories of reliable evidence will be considered, none of which shall be determinative by itself:

1. Whether there is final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the U.S. Food and Drug Administration (FDA); if the drug or device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials; or if the drug, device or medical treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and

2. Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether a drug is included in the American Hospital Formulary Service as appropriate for its proposed use; and

3. Whether there are consensus opinions of national and local health care providers in the applicable specialty as determined by a sampling of providers, including whether there are protocols used by the treating facility or another facility studying the same drug, device, medical treatment or procedure.

Maintenance Care. This is supportive services, including skilled or non-skilled nursing care, to assist you when your condition has not improved or has deteriorated significantly over a measurable period of time (generally a period of two months). Care may be determined to be maintenance care regardless of whether your condition requires skilled medical care or the use of medical equipment.

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

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

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

Medically Necessary Orthodontic Services. This is treatment necessary for the correction of severe malocclusion of teeth and associated dental and facial disfigurement, when such treatment is intended to correct congenital defects and anomalies, or the effects of disease, which result in a functional impairment. Functional impairments include, but are not limited to significant impairment in chewing, breathing or swallowing.

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

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

Non-Formulary Drug. This is a prescription drug, approved by the Food and Drug Administration (FDA), that is not on the formulary, is medically necessary and is not investigative or otherwise excluded under this Plan.

Orthognathic Surgery. This is oral surgery to alter the position of the jaw bones.

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

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

**Periodontics.** This is non-surgical and surgical treatment of diseases of the gingiva (gums) and bone supporting the teeth.

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

**Plan Year.** This is the 12-month period beginning 12:01 A.M. Central Time, on September 1, and ending at midnight
Central Time of the next following August 31.

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

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

**Prosthetic Services.** These are services to replace missing teeth; including the prescribing, repair, construction,
replacement and fitting of fixed bridges and full or partial removable dentures.

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

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

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

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

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

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

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

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. Covered prescription drugs are based on requirements established by the HealthPartners Pharmacy and Therapeutics Committee, and are subject to periodic review and modification. These medical policies (medical coverage criteria) and formulary requirements are available online at www.healthpartners.com/uofmga or by calling Member Services.

A. ACUPUNCTURE

The Plan covers acupuncture services when medically necessary.

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. These medical policies (medical coverage criteria) are available online at www.healthpartners.com/uofmga or by calling Member Services.

B. AMBULANCE AND MEDICAL TRANSPORTATION

The Plan covers certain ambulance and medical transportation for medical emergencies and medically necessary, non-emergency medical transportation if it meets HealthPartners medical coverage criteria.

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. These medical policies (medical coverage criteria) and applicable prior authorization requirements are available online at www.healthpartners.com/uofmga or by calling Member Services.

C. BEHAVIORAL HEALTH SERVICES

1. Mental Health Services

The Plan covers services for mental health diagnoses as described in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM 5) (most recent edition) that lead to significant disruption of function in the Covered Person’s life.

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

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

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

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

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

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

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

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

2. **Chemical Health Services**

The Plan covers medically necessary services for assessments by a licensed alcohol and drug counselor and
treatment of substance-related disorders as defined in the Diagnostic and Statistical Manual of Mental

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

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

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

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

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

Covered services and supplies are based on established medical policies, which are subject to periodic review and
modification by the medical directors. These medical policies (medical coverage criteria) are available online at
www.healthpartners.com/uofmga or by calling Member Services.

D. **CHIROPRACTIC SERVICES**

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

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

The Plan covers certain routine services if you participate in a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition as defined in the Affordable Care Act. The Plan covers routine patient costs for services that would be eligible under this Plan if the service were provided outside a clinical trial.

F. DENTAL SERVICES

The University of Minnesota provides graduate assistant student members with preventive services such as routine exams, X-rays, and cleanings at no cost when performed at the dental clinic designated for each campus. In addition, restorative benefits up to $1,000 annual maximum per plan year are also paid at 80 percent of basic restorative services and 50 percent of major restorative services for graduate assistant student members.

Spouses may obtain preventive and other restorative dental services on a negotiated fee for service basis at a discount of 20-30 percent when using the clinic designated for each campus.

The University pays for Pediatric dental benefits the designated clinics with specific details listed on page 10 and 43 of this document.

Twin Cities Campus Designated Dental Clinic: Boynton Health Dental Clinic, 612-624-9998. Duluth Campus Designated Dental Clinic: Lake Superior Dental Associates, 218-728-6445. See www.shb.umn.edu for details.

Note: Preventive and restorative dental benefits are not provided by HealthPartners. Please contact the Office of Student Health Benefits for more information about preventive and restorative dental benefits.

Services provided by HealthPartners:

1. Accidental Dental Services. The Plan covers dentally necessary services to treat and restore damage done to sound, natural, unrestored teeth as a result of an accidental injury. Coverage is for damage caused by external trauma to face and mouth only, not for cracked or broken teeth which result from biting or chewing. The Plan covers restorations, root canals, crowns and replacement of teeth lost that are directly related to the accident in which the Covered Person was involved. The Plan covers initial exams, x-rays, and palliative treatment including extractions, and other oral surgical procedures directly related to the accident. Subsequent treatment must be initiated within 12 months of the date of the injury and must be related to the accident. The Plan does not cover restoration and replacement of teeth that are not “sound and natural” at the time of the accident.

Full mouth rehabilitation to correct occlusion (bite) and malocclusion (misaligned teeth not due to the accident) are not covered.

When an implant-supported dental prosthetic treatment is pursued, the accidental dental benefit will be applied to the prosthetic procedure. Benefits are limited to the amount that would be paid toward the placement of a removable dental prosthetic appliance that could be used in the absence of implant treatment.

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

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

3. **Oral Surgery.** The Plan covers certain oral surgery. Coverage is limited to treatment of medical conditions requiring oral surgery, such as treatment of oral neoplasm, non-dental cysts, fracture of the jaws and trauma of the mouth and jaws.

4. **Special Oral Surgery.** In addition, the following services are available, as indicated on the Schedule of Benefits: Oral surgery for (1) partially or completely unerupted impacted teeth; and (2) a tooth root without the extraction of the entire tooth (this does not include root canal therapy); and (3) the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

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

6. **Treatment of Cleft Lip and Cleft Palate.** The Plan covers certain treatment of cleft lip and cleft palate, including orthodontic treatment and oral surgery directly related to the cleft. Dental services which are not necessary for the treatment of cleft lip or cleft palate are not covered. If you are covered under a dental plan which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same copayment, conditions and limitations as durable medical equipment.

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

G. **DIAGNOSTIC IMAGING SERVICES**

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

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

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

The Plan covers equipment and services, as described below.

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

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

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

3. Items which are not eligible for coverage include, but are not limited to:
   a. Replacement or repair of any covered items, if the items are: (1) damaged or destroyed by misuse, abuse or carelessness; (2) lost; or (3) stolen.
   b. Duplicate or similar items.
   c. Labor and related charges for repair of any covered items which are more than the cost of replacement by a designated vendor.
   d. Sales tax, mailing, delivery charges, service call charges.
   e. Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience or recreation.
   f. Communication aids or devices: equipment to create, replace or augment communication abilities including, but not limited to, speech processors, receivers, communication boards, or computer or electronic assisted communication, except as specifically described in this SB. This exclusion does not apply to cochlear implants, which are covered as described in the medical coverage criteria. These medical policies (medical coverage criteria) are available by calling Member Services, or online at www.healthpartners.com/uofmga.
   g. Household equipment which primarily has customary uses other than medical, such as, but not limited to, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds.
   h. Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools, whirlpools and saunas.
   i. Modifications to the structure of the home including, but not limited to, its wiring, plumbing or charges for installation of equipment.
   j. Vehicle, car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carriers.
   k. Rental equipment while the Covered Person’s owned equipment is being repaired, beyond one month rental of medically necessary equipment.
   l. Other equipment and supplies, including but not limited to assistive devices, that the Plan determines are not eligible for coverage.

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

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

I. EMERGENCY AND URGENT CARE SERVICES

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

Emergency Care. These are services to treat: (1) the sudden, unexpected onset of illness or injury which, if left untreated or unattended until the next available clinic or office hours, would result in hospitalization; or (2) a condition requiring professional health services immediately necessary to preserve life or stabilize health. When reviewing claims for coverage of emergency services, our medical director will take into consideration a reasonable layperson’s belief that the circumstances required immediate medical care that could not wait until the next working day or next available clinic appointment.
The Plan **must be** notified within two working days of admission to an out-of-network hospital, or as soon as reasonably possible under the circumstances.

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

**Emergency Travel Assistance Program.** Plan members and their dependents traveling 100 or more miles away from home and outside of their home country, have emergency medical, travel and personal security assistance 24 hours a day, anywhere in the world. This benefit is not offered by HealthPartners. It is provided by the University of Minnesota. For more information, go to www.shb.umn.edu.

**J. HEALTH EDUCATION**

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

**K. HEARING AID BENEFIT**

The Plan covers evaluation for the need for a hearing aid and medically necessary hearing aids when arranged through and authorized by a network physician. This benefit is limited to one hearing aid per ear for each member in each three plan year period. A hearing aid appliance is limited to one of the following types:

1. in-the-ear;
2. behind-the-ear (air or bone conduction);
3. conventional (on the body); or
4. eye glass frame hearing appliance.

The appliance must be prescribed by a network physician. If another type of hearing aid appliance is prescribed, the current average dollar cost for the above named appliances shall be the amount which is covered toward the cost of such other appliance.

**L. HOME HEALTH SERVICES**

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

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

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

You do not need to be homebound to receive total parenteral nutrition/intravenous (“TPN/IV”) therapy. Home health services are eligible and covered only when they are:

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

Home health services are not provided as a substitute for a primary caregiver in the home or as relief (respite) for a primary caregiver in the home. The Plan will not reimburse family members or residents in the Covered Person’s home for the above services.
A service shall not be considered a skilled nursing service merely because it is performed by, or under the direct supervision of, a licensed nurse. Where a service (such as tracheotomy suctioning or ventilator monitoring or like services) can be safely and effectively performed by a non-medical person (or self-administered), without the direct supervision of a licensed nurse, the service shall not be regarded as a skilled nursing service, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it a skilled service when a skilled nurse provides it. Only the skilled nursing component of so-called “blended” services (i.e., services which include skilled and non-skilled components) are covered under the Plan.

M. HOME HOSPICE SERVICES

Applicable Definitions:

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

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

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

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

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

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

   b. Eligible Services: Hospice services include the following services provided by Medicare-certified providers, if provided in accordance with an approved hospice treatment plan.
      (1) Home Health Services:
         (a) Part-time care provided in the Covered Person’s home by an interdisciplinary hospice team (which may include a physician, nurse, social worker, and spiritual counselor) and medically necessary home health services are covered.
         (b) One or more periods of continuous care in the Covered Person’s home or in a setting which provides day care for pain or symptom management, when medically necessary, will be covered.
      (2) Inpatient Services: The Plan covers medically necessary inpatient services.
      (3) Other Services:
         (a) Respite care is covered for care in the Covered Person’s home or in an appropriate facility, to give the patient’s primary caregivers (i.e., family members or friends) rest and/or relief when necessary in order to maintain a terminally ill patient at home.
         (b) Medically necessary medications for pain and symptom management.
         (c) Medically necessary semi-electric hospital beds and other durable medical equipment are covered.
         (d) Medically necessary emergency and non-emergency care are covered.
2. **What Is Not Covered.** The Plan does not cover the following services:
   a. financial or legal counseling services; or
   b. housekeeping or meal services in the patient’s home; or
   c. custodial care related to hospice services, whether provided in the home or in a nursing home; or
   d. any service not specifically described as a covered service under this home hospice services section; or
   e. any services provided by a member of the patient’s family or resident in the Covered Person’s home.

N. **HOSPITAL AND SKILLED NURSING FACILITY SERVICES**

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

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

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

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

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

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

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

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

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

   For Network Benefits, non-emergency, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) must be provided at a designated facility.
To see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see the benefits under Diagnostic Imaging Services, Laboratory Services and Physical Therapy in the Schedule of Benefits.

2. **Skilled Nursing Facility Care.**

   The Plan covers room and board, daily skilled nursing and related ancillary services for post-acute treatment and rehabilitative care of illness or injury that meets medical coverage criteria.

O. **INFERTILITY SERVICES**

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

P. **LABORATORY SERVICES**

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

Q. **MASTECTOMY RECONSTRUCTION BENEFIT**

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

R. **OFFICE VISITS FOR ILLNESS OR INJURY**

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

   The Plan also covers diagnosis and treatment of illness or injury to the eyes, including contact lenses for Pathological Myopia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-Traumatic Disorders or Irregular Astigmatism. Where contact or eyeglass lenses are prescribed as medically necessary for the post-operative treatment of cataracts or for the treatment of aphakia or keratoconus, the initial evaluation, lenses and fitting are covered under the Plan. Covered Persons must pay for lens replacement beyond the initial pair.

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

S. **PEDIATRIC DENTAL SERVICES**

   The Plan covers the following services for Covered Persons up to age 19:

1. Preventive care and diagnostic services:
   - Routine dental care examinations for new and existing patients.
   - Dental cleaning (prophylaxis or periodontal maintenance cleaning).
   - Professionally applied topical fluoride.
   - Pit and fissure sealant application and preventive resin restoration.
   - Bitewing x-rays and dental x-rays as required in conjunction with the diagnosis of a specific condition requiring treatment, except x-rays provided in connection with orthodontic diagnostic procedures and treatment.
   - Full mouth or panoramic x-rays.
   - Space maintainers (fixed or removable appliances designed to prevent adjacent and opposing teeth from moving).
   - Evaluations that are not routine and periodic, including: problem-focused evaluations (either limited or detailed and extensive), periodontal evaluations, and evaluations for Covered Persons under age 3 which include counseling with the primary caregiver.
   - Screening or assessments of a patient.
   - Periodontics (Gum Disease) – surgical and non-surgical treatment.
2. **Basic Services:**
   - Emergency treatment for the relief of pain.
   - Regular restorative services (fillings) other than posterior composites. Restorations using customary restorative materials and stainless steel crowns are covered, when dentally necessary due to loss of tooth structure as a result of tooth decay or fracture.
   - Regular restorative services (fillings) - posterior composites (white fillings on bicuspids and molars). Restorations using customary restorative materials and preventive resin restorations are covered, when dentally necessary due to loss of tooth structure as a result of tooth decay or fracture.
   - Oral Surgery - non-surgical extraction for the restoration of dental function, and other services including, but not limited to: removal of impacted teeth, incision or drainage of abscesses and removal of exostosis. General anesthesia or intravenous sedation is covered, when dentally necessary, when provided by the attending dentist in a dental office setting and required to perform a covered dental procedure.
   - Endodontics, including pulpal regeneration.

3. **Major Services:**
   - Bridges - initial installation of fixed bridgework to replace missing natural teeth, replacement of an existing fixed bridgework by new bridgework, the addition of teeth to an existing bridgework, and repair or recementing of bridgework are covered. A given prosthetic appliance for the purpose of replacing an existing appliance will be provided when satisfactory evidence is presented that the new prosthetic appliance is required to replace one or more teeth extracted after the existing bridgework was installed.
   - Dentures - initial installation of full removable dentures to replace missing natural teeth and adjacent structures and adjustments during the six-month period following installation are covered. If a satisfactory result can be achieved through the utilization of standard procedures and materials but a personalized appliance is selected, or one which involves specialized techniques, the charges appropriate to the least costly appliance are covered. Replacement of an existing full removable denture by a new denture is covered. A given prosthetic appliance for the purpose of replacing an existing appliance will be provided when satisfactory evidence is presented that the new prosthetic appliance is required to replace one or more teeth extracted after the existing denture was installed. Repair of dentures, or relining or rebasing of dentures more than six months after installation of an initial or replacement denture are covered.
   - Partial Dentures - removable partial denture are covered. Initial installation of partial removable dentures to replace missing natural teeth and adjacent structures and adjustments during the six-month period following installation are covered. If a satisfactory result can be achieved by a standard cast chrome or acrylic partial denture, but a more complicated design is selected, the charges appropriate to the least costly appliance are covered. Replacement of an existing partial denture by a new denture, or the addition of teeth to an existing partial removable denture is covered. A given prosthetic appliance for the purpose of replacing an existing appliance will be provided when satisfactory evidence is presented that the new prosthetic appliance is required to replace one or more teeth extracted after the existing denture was installed. Repair of dentures, or relining or rebasing of dentures more than six months after installation of an initial or replacement denture are covered.

4. **Medically Necessary Orthodontic Services:**
   - Medically necessary orthodontic services necessary for the correction of severe malocclusion of teeth and associated dental and facial disfigurement. Orthodontia may be considered medically necessary when the treatment is intended to correct congenital defects and anomalies, or the effects of disease, when they result in a functional impairment. Functional impairments include but are not limited to significant impairment in chewing, breathing or swallowing. Each orthodontic treatment includes: (1) treatment necessary for the correction of malocclusion of teeth and associated dental and facial disfigurement, and (2) initial post-treatment retainers.

5. **The Plan does not cover the following:**
   - Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
   - Services and treatment which are experimental or investigational;
• Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
• Services and treatment performed prior to your effective date of coverage;
• Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
• Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice.
• Services and treatment resulting from your failure to comply with professionally prescribed treatment;
• Telephone consultations;
• Any charges for failure to keep a scheduled appointment;
• Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
• Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);
• Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
• Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist;
• Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
• Those for which the member would have no obligation to pay in the absence of this or any similar coverage;
• Those which are for specialized procedures and techniques;
• Those performed by a dentist who is compensated by a facility for similar covered services performed for members;
• Duplicate, provisional and temporary devices, appliances, and services;
• Plaque control programs, oral hygiene instruction, and dietary instructions;
• Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
• Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;
• Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient), except as specifically stated in this SB;
• Use of material or home health aides to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
• Cone Beam Imaging and Cone Beam MRI procedures;
• Sealants for teeth other than permanent molars;
• Precision attachments, personalization, precious metal bases and other specialized techniques;
• Repair of damaged orthodontic appliances;
• Replacement of lost or missing appliances;
• Fabrication of athletic mouth guard;
• Internal and external bleaching;
• Nitrous oxide;
• Oral sedation;
• Topical medicament center;
• Orthodontic care for a member or spouse;
• Bone grafts when done in connection with extractions, apicoectomies or non-covered/non eligible implants.
T. PEDIATRIC EYEWEAR

The Plan covers pediatric eyewear for children up to age 19. Coverage continues until the end of the month in which the child turns age 19.

The Plan covers contact lenses for Pathological Myopia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-Traumatic Disorders or Irregular Astigmatism.

This plan also covers lenses including single, bifocal, trifocal, lenticular lens powers, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses; polycarbonate prescription lenses with scratch resistance coating and low vision services.

Where contact or eyeglass lenses are prescribed as medically necessary for the post-operative treatment of cataracts or for the treatment of aphakia or keratoconus, the initial evaluation, lenses and fitting are covered under the Plan. Covered Persons must pay for lens replacement beyond the initial pair.

U. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY

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

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

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

V. PRESCRIPTION DRUG SERVICES

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

W. PREVENTIVE SERVICES

The Plan covers the following preventive services:

1. Routine health exams and periodic health assessments. A physician or health care provider will counsel Covered Persons as to how often health assessments are needed based on the age, sex and health status of the Covered Person. This includes counseling for tobacco cessation.
2. Child health supervision services, including pediatric preventive services, routine immunizations, developmental assessments and laboratory services appropriate to the age of the child from birth to 72 months, and appropriate immunizations to age 18.
3. Routine prenatal care and exams to include visit-specific screening tests, education and counseling.
4. Routine postnatal care and exams to include health exams, assessments, education and counseling relating to the period immediately after childbirth.
5. Routine screening procedures for cancer.
6. Routine eye and hearing exams.
7. Professional voluntary family planning services.
8. Adult immunizations.
9. Women’s preventive health services; including mammograms, screenings for cervical cancer; breast pumps; human papillomavirus (HPV) testing; counseling for sexually transmitted infections; counseling and screening for human immunodeficiency virus (HIV); and FDA approved contraceptive methods, sterilization procedures, education and counseling, including those listed below:
   • Surgical implants
   • Insertion and removal of implantable devices
   • Cervical cap supplies and services
   • Diaphragm supplies and services
   • Insertion and removal of IUDs.
10. Obesity screening and counseling is covered for all ages during a routine preventive care exam. If you are age 18 or older and have a body mass index of 30 or more, intensive obesity management is covered to help you lose weight. Your primary care physician can coordinate the services.
All services required under the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA) are covered.

A list of preventive services that must be covered at the Network Benefit level at 100% is published by the federal government. Covered services are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. These medical policies (medical coverage criteria) are available online at www.healthpartners.com/uofmga or by calling Member Services.

X. SPECIFIED OUT-OF-NETWORK SERVICES

The Plan covers the following services, when a Covered Person elects to receive them from an out-of-network provider, at the same level of coverage the Plan provides when a Covered Person elects to receive the services from a network provider:
1. Voluntary family planning of the conception and bearing of children.
2. The provider visit(s) and test(s) necessary to make a diagnosis of infertility.
3. Testing and treatment of sexually transmitted diseases (other than HIV).
4. Testing for AIDS and other HIV-related conditions.

Y. TELEMEDICINE BENEFIT

The Plan covers telemedicine services that meet HealthPartners medical coverage criteria.

Z. TRANSPLANT SERVICES

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

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

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

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

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

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

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

**What is Covered.** The Plan covers eligible Transplant Services (as defined above) while you are a Covered Person. Transplants that will be considered for coverage are limited to the following:
1. Kidney transplants for end-stage disease.
2. Cornea transplants for end-stage disease.
3. Heart transplants for end-stage disease.
4. Lung transplants or heart/lung transplants for: (a) primary pulmonary hypertension; (b) Eisenmenger’s syndrome; (c) end-stage pulmonary fibrosis; (d) alpha 1 antitrypsin disease; (e) cystic fibrosis; and (f) emphysema.
5. Liver transplants for: (a) biliary atresia in children; (b) primary biliary cirrhosis; (c) post-acute viral infection (including hepatitis A, hepatitis B antigen e negative and hepatitis C) causing acute atrophy or post-necrotic cirrhosis; (d) primary sclerosing cholangitis; (e) alcoholic cirrhosis; and (f) hepatocellular carcinoma.

6. Allogeneic bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for: (a) acute myelogenous leukemia; (b) acute lymphocytic leukemia; (c) chronic myelogenous leukemia; (d) severe combined immunodeficiency disease; (e) Wiskott-Aldrich syndrome; (f) aplastic anemia; (g) sickle cell anemia; (h) non-relapsed or relapsed non-Hodgkin’s lymphoma; (i) multiple myeloma; and (j) testicular cancer.

7. Autologous bone marrow transplants or peripheral stem cell support associated with high-dose chemotherapy for: (a) acute leukemias; (b) non-Hodgkin’s lymphoma; (c) Hodgkin’s disease; (d) Burkitt’s lymphoma; (e) neuroblastoma; (f) multiple myeloma; (g) chronic myelogenous leukemia; and (h) non-relapsed non-Hodgkin’s lymphoma.


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

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

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

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

AA. WEIGHT LOSS SURGERY OR BARIATRIC SURGERY

Covered services are based on established medical policies, which are subject to periodic review and modification by the medical directors. These medical policies (medical coverage criteria) are available by calling Member Services or online at www.healthpartners.com/uofmga.

IV. EXCLUSIONS

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

1. Treatment, procedures, services or drugs which are not medically necessary and/or which are primarily educational in nature or for the vocation, comfort, convenience, appearance or recreation of the Covered Person, including skills training.

2. For Network Benefits, treatment, procedures or services which are not provided by a network provider.

3. Procedures, technologies, treatments, facilities, equipment, drugs and devices which are considered investigative, or otherwise not clinically accepted medical services. The Plan considers vagus nerve stimulator treatment for the treatment of depression and Quantitative Electroencephalogram treatment for the treatment of behavioral health conditions to be investigative and do not cover these services. The Plan considers the following transplants to be investigative and does not cover them: surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, non-human organ implants and/or transplants and other transplants not specifically listed in this SB. While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered.

4. Rest and respite services and custodial care, except as specified under the Home Hospice benefit. This includes all services, medical equipment and drugs provided for such care.

5. Room and board and care provided in halfway houses, extended care facilities, or comparable facilities, and residential treatment services (except for psychiatric residential treatment for emotionally disabled children, residential care for the treatment of eating disorders and chemical health treatment in a licensed residential primary treatment center as specified in the “Behavioral Health” section).

6. Foster care, adult foster care and any type of family child care provided or arranged by the local state or county.
7. Services associated with non-covered services, including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies.
8. Services from non-medically licensed facilities or providers and services outside the scope of practice or license of the individual or facility providing the service.
9. Cosmetic surgery, cosmetic services and treatments primarily for the improvement of the Covered Person’s appearance or self-esteem, including, but not limited to, augmentation procedures, reduction procedures and scar revision. This exclusion does not apply to services for port wine stain removal and reconstructive surgery.
10. Commercial weight loss programs and exercise programs.
11. Dental treatment, procedures or services not listed in this SB.
12. Vocational rehabilitation and recreational or educational therapy.
13. Health services and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise medically necessary, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) competency evaluations, and adoption studies.
14. Reversal of sterilization; assisted reproduction, including, but not limited to gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), intracytoplasmic sperm injection (ICSI) and/or in-vitro fertilization (IVF), and all charges associated with such procedures; treatment of infertility after reversal of sterilization; artificial insemination when not medically necessary for the treatment of a Covered Person’s medically diagnosed infertility; sperm, ova or embryo acquisition, retrieval or storage.
15. Services related to the establishment of surrogate pregnancy and fees for a surrogate.
16. Keratotomy and keratorefractive surgeries, eyeglasses or contact lenses and their fitting, measurement and adjustment, and hearing aids (implantable and external, including osseointegrated or bone anchored) and their fitting, except as specifically described in this SB. This exclusion does not apply to cochlear implants, which are covered as described in the medical coverage criteria. Medical coverage criteria are available by calling Member Services, or on www.healthpartners.com/uofmga.
17. Medical Food. Enteral feedings, unless they are the sole source of nutrition used to treat a life-threatening condition, nutritional supplements, over-the-counter electrolyte supplements and infant formula, except as specified in this SB. This exclusion does not apply to oral amino acid based elemental formula or other items if they meet HealthPartners medical coverage criteria.
18. Charges for sales tax.
19. Services provided by a family member of the Covered Person, or a resident in the Covered Person’s home.
21. Private duty nursing services.
22. Services that are rendered to a Covered Person, who also has other primary insurance coverage for those services and who does not provide the Plan the necessary information to pursue coordination of benefits, as required under the Plan.
23. The portion of a billed charge for an otherwise covered service by a provider, which is in excess of the usual and customary charges, or which is either a duplicate charge for a service or charges for a duplicate service.
24. Charges for services (a) for which a charge would not have been made in the absence of insurance or medical plan coverage, or (b) which the Covered Person is not legally obligated to pay, and (c) from providers who waive copayment, deductible and coinsurance payments by the Covered Person.
25. Travel and lodging incidental to travel, regardless if it is recommended by a physician and any travel billed by a provider.
27. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
28. Autopies.
29. For Network Benefits, charges incurred for transplants, Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) received at facilities which are not designated facilities, or charges incurred for weight loss services provided by a physician who is not a designated physician.
30. Accident related dental services if treatment is (1) provided to teeth which are not sound and natural, (2) to teeth which have been restored, (3) initiated beyond 12 months from the date of the injury, (4) received beyond the initial treatment or restorations, or (5) received beyond 24 months from the date of injury.
31. Nonprescription (over-the-counter) drugs or medications, unless listed on the formulary and prescribed by a physician or legally authorized health care provider under applicable state law, including, but not limited to, vitamins, supplements, homeopathic remedies, and non-FDA approved drugs. This exclusion does not include over-the-counter contraceptives for women as allowed under the Affordable Care Act when the Covered Person obtains a prescription for the item, and benefits provided for all of the services required under USPSTF, ACIP and HRSA.
32. Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders, including ABA, IEIBT, and Lovaas.
33. Charges for elective home births.
34. Professional services associated with substance abuse intervention. A “substance abuse intervention” is a gathering of family and/or friends to encourage a person covered under this SB to seek substance abuse treatment.
35. Court ordered treatment, except as described under “Mental Health Services” and “Office Visits for Illness and Injury” or as otherwise required by law.
36. Services provided through scheduled telephone visits, services provided through E-Visits.
37. Charges provided by naturopathic providers.
38. Treatment, procedures, or services or drugs which are provided when you are not covered under this Plan.
39. Care that is not rehabilitative in nature and medically necessary for the diagnosis and/or treatment of acute neuromusculoskeletal conditions.
40. Medication Therapy Disease Management consultation.
41. Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
42. Non-medical administrative fees and charges including, but not limited to, medical record preparation charges, appointment cancellation fees, after hours appointment charges, and interest charges.
43. Replacement of eyeglasses or contact lenses due to loss or theft.
44. Contact lenses for cosmetic purposes.
45. Medical cannabis.
46. Drugs on the Excluded Drug List. The Excluded Drug List includes select drugs within a therapy class that are not eligible for coverage.

V. DISPUTES AND COMPLAINTS

A. DETERMINATION OF COVERAGE

Eligible services are covered only when medically or dentally necessary for the proper treatment of a Covered Person. HealthPartners medical or dental directors, or their designees, make coverage determinations of medical necessity, restrictions on access and appropriateness of treatment, and they make final authorization for covered services. In certain circumstances where prior authorization is required for a covered service, Covered Persons may be directed by the Plan Manager to the most cost-effective site of care to receive covered services. If the site to which the Covered Person is being directed has a higher cost to the Covered Person than the original physician directed site of care, the benefit category with the lower cost to the Covered Person will apply.

Covered prescription drugs are based on requirements established by the HealthPartners Pharmacy and Therapeutics Committee, and are subject to periodic review and modification.

Coverage determinations are based on established dental/medical policies, which are subject to periodic review and modification by HealthPartners’ dental or medical directors. Frequency limits, deductibles, copayments or coinsurance, or other maximums or limits for certain covered pediatric dental services may not apply for certain medical conditions if you meet specific coverage criteria set by our dental directors.

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

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

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

VI. CONDITIONS

A. RIGHTS OF REIMBURSEMENT AND SUBROGATION

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

In addition, the Plan will have a lien on any amounts payable by a third party or under an insurance policy or program, to the extent covered expenses are paid by the Plan Sponsor’s Medical Benefit Plan. The rights of reimbursement and subrogation apply whether or not the Covered Person has been fully compensated for losses or damages by any recovery of payments, and the Plan Sponsor or its designee will be entitled to immediately collect the present value of subrogation rights from said payments.

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

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

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

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

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

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

2. Definitions.
   a. “Plan” is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
      (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
      (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).
      Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.
   b. “The Plan” is the part of the Plan that provides benefits for medical care expenses.
   c. “Primary Plan/Secondary Plan” The order of benefit determination rules state whether The Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When The Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan’s benefits.
      When The Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan’s benefits.
      When there are more than two plans covering the person, The Plan may be a Primary Plan as to one or more of the plans and may be a Secondary Plan as to a different plan or plans.
   d. “Allowable Expense” is a necessary, reasonable and customary item of expense for medical care when the item of expense is covered at least in part by or more plans covering the person for whom the claim is made.
      The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient’s stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.
      When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.
      When benefits are reduced under a primary plan because a Covered Person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements.
   e. “Claim Determination Period” is a plan year. However, it does not include any part of a year during which a person has no coverage under The Plan, or any part of a year before the date this COB provision or a similar provision takes effect.
3. **Order of Benefit Determination Rules.**
   a. **General.** When there is a basis for a claim under The Plan and another plan, The Plan is a Secondary Plan which has its benefits determined after those of another plan, unless:
      (1) the other plan has rules coordinating its benefits with those of The Plan; and
      (2) both those rules and The Plan’s rules, in subparagraph b. below, require that The Plan’s benefits be determined before those of the other plan.
   b. **Rules.** The order of benefits are determined using the first of the following rules which applies:
      (1) Nondependent/Dependent. The benefits of the plan which cover the person as a Covered Person or subscriber (that is, other than as a dependent) are determined before those of the plan which cover the person as a dependent.
      (2) Dependent Child/Parents not Separated or Divorced. Except as stated in subparagraph b. (3) below, when The Plan and another plan cover the same child as a dependent of different persons, called “parents”:
         (a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
         (b) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
      (3) Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
         (a) first, the plan of the parent with custody of the child;
         (b) then, the plan of the spouse of the parent with the custody of the child; and
         (c) finally, the plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the medical care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
      (4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for medical care expenses of the child, the plans covering the child follow the order of benefit determination rules outlined in subparagraph b. (2).
      (5) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered a Covered Person or subscriber longer are determined before those of the plan which covered that person for the shorter term.

4. **Effect on the Benefits of This Plan.**
   a. **When this Section Applies.** This paragraph 4. applies when, in accordance with paragraph 3. “Order of Benefit Determination Rules,” The Plan is a Secondary Plan as to one or more other plans. In that event the benefits of The Plan may be reduced under this section. Such other plan or plans are referred to as “the other plans” in b. immediately below.
   b. **Reduction in the Plan’s Benefits.** The benefits of The Plan will be reduced when the sum of:
      (1) the benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
      (2) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of The Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses. When the benefits of The Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of The Plan.
   c. **Benefit Reserve.** The Secondary Plan shall calculate its savings by subtracting the amount that it paid as a Secondary Plan from the amount it would have paid had it been primary “COB Savings”. These COB Savings shall be recorded in the benefit reserve for the Covered Person and shall be used by the
Secondary Plan to pay any allowable expenses, not otherwise paid, that are incurred by the Covered Person during the Claim Determination Period. As each claim is submitted, the Secondary Plan must:

1. determine its obligation, pursuant to the contract;
2. determine whether a benefit reserve has been recorded for the Covered Person; and
3. determine whether there are any unpaid allowable expenses during that Claim Determination Period.

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

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

6. Facility of Payment. A payment made under another plan may include an amount which should have been paid under The Plan. If it does, the Plan Sponsor may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under The Plan. The Plan Sponsor will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

7. Right of Recovery. If the amount of the payments made by the Plan Sponsor is more than the amount that should have paid under this COB provision, the Plan Manager may recover the excess from one or more of:
   a. the persons it has paid or for whom it has paid;
   b. insurance companies; or
   c. other organizations.

The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

The benefits provided by the Plan do not apply to injury or disease covered by no-fault insurance, employers liability laws (including workers’ compensation), and care available or required to be furnished by or through national or state governments or their agencies including care to which a Covered Person is legally entitled and for which facilities are reasonably available for military service-connected conditions or disabilities.

Subject to the Plan’s rights in A. “Rights of Reimbursement and Subrogation” above, medically necessary services will be provided upon request and only expenses incurred for medical treatment otherwise covered by the Plan will be paid if the no-fault insurer, employer, or national or state government or its agencies refuse to pay said expenses. You must cooperate with the Plan Manager’s program to bill allowable no-fault and workers’ compensation claims to the appropriate insurer(s).

C. MEDICARE AND THE PLAN

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

In general, Medicare is secondary payer for Medicare enrollees who: (1) are active employees and (2) are covered by Medicare because they have reached age 65 when there are 20 or more employees in the group. The Medicare secondary payer rules change from time to time and the most recent rule will be applied.
Medicare is the primary payer:
1. For Covered Persons with end stage renal disease, after the 30 month period following the earlier of (1) the month in which the Covered Person begins a regular course of renal dialysis, or (2) the first of the month in which the Covered Person became entitled to Medicare, if the Covered Person received a kidney transplant without first beginning dialysis. This is regardless of the size of the Employer.
2. For retirees who are age 65 or over.
3. For Covered Persons under age 65, who are covered by Medicare because of disability (other than end stage renal disease), when (1) the Employer employs fewer than 100 employees and the Covered Person or their spouse or parent has group health plan coverage due to current employment, or (2) the Covered Person or their spouse or parent has coverage not due to current employment, regardless of the number of employees of the Employer.

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

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

If Medicare is the primary payer, the benefits under the Plan will only be reduced to the extent that the Covered Person has actually enrolled in Medicare.

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

VII. CONTINUATION OF COVERAGE

After losing eligibility for the plan, a student has the option to continue coverage for up to 18 months at his or her own expense. To continue coverage, you must apply for continuation within 60 days of losing eligibility. You must complete the Continuation of Coverage Form and return it to the Office of Student Health Benefits. Dependent coverage may also be continued on the same terms as previously enrolled but the insured will pay the full cost of dependent coverage. Insurance premiums must be paid in a timely manner and failure to do so by the payment due date will result in a loss of coverage. The first payment by the student will be for coverage from the date of loss of eligibility through the current month plus one month in advance, and may reflect several months’ coverage if enrollment for continuation coverage has been delayed. Payments are made directly to the University of Minnesota and sent to the Office of Student Health Benefits. The payment due date is the 20th of the month preceding 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 Graduate Assistant Health Plan to the end of the policy year. A written application must, however, be made to the Office of Student Health Benefits. Also, the cost of coverage must be paid to the Office of Student Health Benefits. Failure of the survivor to make payments for coverage within 90 days after notice of the requirement to pay shall be a basis for discontinuation of coverage without written consent of the survivor. The Office of Student Health Benefits will mail a written notice of cancellation to the survivor’s last known address at least 30 days prior to the discontinuation of coverage.

Coverage may be continued when a Covered Student becomes enrolled in Medicare or when dependent children cease to be eligible as dependent children. No evidence of insurability will be required. A written application must, however, be made to the Office of Student Health Benefits. Also, the first semester cost of coverage must be paid to the Office of Student Health Benefits within thirty-one (31) days of the date that the coverage would have ended.

VIII. CLAIMS PROCEDURES
A. PROCEDURES FOR REIMBURSEMENT OF NETWORK SERVICES

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

B. PROCEDURES FOR REIMBURSEMENT OF SERVICES

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

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

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

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

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

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

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

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

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

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

2. Post-Service Claims.

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

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

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

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

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

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

   For questions about your rights, or for assistance, you can contact the Health Insurance Assistance Team (HIAT) at the U. S. Department of Health and Human Services at 1-888-393-2789.

   If your question relates to eligibility, enrollment, or other administrative issue, the Plan Administrator will refer your request to the University of Minnesota Office of Student Health Benefits.

   Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.
The Plan Manager will review your appeal and will notify you of its decision in accordance with the following timelines:

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

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

The time periods may be extended if you agree.

**Concurrent Care Appeal.** If you are appealing a reduction or termination of an ongoing course of treatment that has been previously approved by HealthPartners, you will have continued coverage under the Plan, pending the outcome of the appeal. This does not apply to requests for an extension to the already approved period of treatment or number of visits.

All notifications described above will comply with applicable law.

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

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

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

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

   The time periods may be extended if you agree.

All notifications described above will comply with applicable law.

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

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

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

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

   For questions about your rights, or for assistance, you can contact the Health Insurance Assistance Team (HIAT) at the U. S. Department of Health and Human Services at 1-888-393-2789.
Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

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

The time period may be extended if you agree.

**Concurrent Care Appeal.** If you are appealing a reduction or termination of an ongoing course of treatment that has been previously approved by HealthPartners, you will have continued coverage under the Plan, pending the outcome of the appeal. This does not apply to requests for an extension to the already approved period of treatment or number of visits.

All notifications described above will comply with applicable law.

If your question relates to eligibility, enrollment, or other administrative issue, the Plan Administrator will refer your request to the University of Minnesota Office of Student Health Benefits. You may contact the Office of Student Health Benefits by phone at 612-624-0627, or by fax 612-626-5183, or by email at umshbo@umn.edu, or by mail to Office of Student Health Benefits, Boynton Health, 410 Church Street S.E., 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 Office of Student Health Benefits representative will first assist you in trying to resolve the concern on an informal basis. If you are unable to resolve your concern informally and wish to pursue the matter, a written request for review, including the concerns you have about your eligibility, enrollment, or other administrative issue, plus supporting documentation must be submitted. You will receive a telephone or written response from the Office of Student Health Benefits as soon as possible, but not later than 30 days following the Office’s receipt of your request for review.

Office of Student Health Benefits Committee Review of Coverage Denials - If you do not agree with the response from the Office of Student Health Benefits concerning an eligibility, enrollment, or other administrative issue, you may request a review by the Office of Student Health Benefits Appeals Committee. Your request must be in writing and be received by one of the communication ways listed above within 60 days of the denial of response from the Office of Student Health Benefits. A written decision will be mailed to you from the Appeals Committee within 30 days of the receipt of your request for review.

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

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

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

The time periods may be extended if you agree.

All notifications described above will comply with applicable law.
F. EXTERNAL REVIEW PROCEDURES. You or your authorized representative must request an external review within four months of the adverse decision. If your claim is denied because of an adverse benefit determination based on medical judgment, you have the right to request an external review, as described below.

An adverse benefit determination is a denial, reduction, or termination of, or failure to provide or make payment for a benefit for any of the following reasons:

- Failure to provide or make payment for a benefit based on a utilization review.
- Failure to provide or make payment for a benefit based on a determination that the benefit is experimental or investigational.

In addition, an adverse benefit determination includes a rescission of coverage. A rescission is a discontinuance or cancellation of coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission if it is effective retroactively because of a failure to pay premiums or contributions on a timely basis.

- If you have an adverse benefit determination as defined above, you have the right to request external review.
- To initiate the external review process, you may submit a written request for an external review to the Plan Manager. A fee may be required.
- A request for an expedited external review may be made if the adverse benefit determination involves a Covered Person with a medical condition for which the time frame for completion would seriously jeopardize the life or health of the Covered Person or the ability to regain maximum function or involves a determination that concerns an admission, availability of care, continued stay, or health care item or service for which the Covered Person received emergency services, but has not been discharged from a facility.
- Upon receipt of the request for external review, the Independent Review Organization must provide immediate notice of the review to the complainant and to the Plan Manager. Within 10 business days, the Covered Person and the Plan Manager must provide the reviewer with any information they wish to be considered. The Covered Person (who may be assisted or represented by a person of their choice) and the Plan Manager shall be given an opportunity to present their versions of the facts and arguments. Any aspect of the external review involving medical determinations must be performed by a health care professional with expertise in the medical issue being reviewed.
- An external review decision must be made as soon as possible, but no later than 45 days after receipt of the request for external review. The decision is binding on the Plan and the Covered Person. Prompt written notice of the decision and the reasons for it must be sent to the Covered Person and to the Plan Manager. For an expedited external review, the Independent Review Organization will provide notice of the final review decision as expeditiously as the medical condition or circumstances require, but in no event more than 72 hours after the Independent Review Organization receives the request for the expedited external review.

Decisions of the IRO related to the medical necessity of the claim will be considered final.