Be prepared for the possibility of a medical emergency before the need arises by knowing your clinic’s procedure for care needed after regular clinic hours.

Name of your clinic: ____________________________________________________________

Address: ___________________________________________________________________

Phone: _____________________________________________________________________

Name of the hospital used by your clinic: __________________________________________

Address: ___________________________________________________________________

Phone: _____________________________________________________________________

If you face a medical emergency, call 911 or go immediately to the nearest emergency facility.

The Medica CallLink nurse line is available to you in all of the medical plan options. The phone number is on the back of your medical ID card.

UNITEDHEALTHCARE GLOBAL
Global Medical Assistance Program for worldwide emergency medical assistance and other travel assistance services when you are 100 or more miles away from home. This program also includes assistance, evacuation, and repatriation coverage for instances where there is a political or natural disaster emergency, and you need help to protect your own safety and potentially get out of the area.

Call the toll free number that corresponds to the country in which you are traveling or call collect to 410-453-6330 (Baltimore, Maryland) to reach a UnitedHealthcare Global Assistance Center.

BENEFIT QUESTIONS
You can reach the Employee Benefits Service Center at 612-624-8647 or 1-800-756-2363, select option 1, or email benefits@umn.edu.

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see Page 101 for more details.

RESIDENTS/FELLOWS
Residents/fellows in job codes 9541, 9548, 9549, 9552, 9553, 9554, 9555, 9556, 9559, 9568, 9582, 9583, and 9569 are not covered in this plan, but are covered in the University of Minnesota Residents/Fellows plan that is available at the following link: https://shb.umn.edu/health-plans/rfi
This Summary of Benefits is intended to describe the coverage you have for medical benefits under the University of Minnesota UPlan (the Plan) in Plan Year 2018. This booklet describes the eligibility provisions of the Plan, the events that can cause you to lose coverage, your rights to continue coverage when you or your dependents are no longer eligible to participate in the Plan, your rights to convert coverage to an individual policy under certain circumstances, and your rights to appeal a coverage decision or claim denial.

You will find a description of the medical and pharmacy benefits covered under the Plan in this Summary of Benefits, including treatment of illness and injury through office visits, surgical procedures, hospitalizations, lab tests, mental health and substance abuse programs, prescription drugs, therapy, and other treatment methods. You will read about the levels of coverage under the Plan, the deductibles and copayments that are your responsibility and the requirements for pre-authorization and case management that apply to certain benefit coverages. You will also read about the wellness program, emergency medical assistance program, travel program, and other benefits available to you as part of the Plan.

Medica administers the claims, along with Prime Therapeutics, the pharmacy benefits manager, Fairview Specialty Pharmacy, the exclusive provider of most specialty medications, and RedBrick Health Corporation, the wellbeing program administrator.

At Open Enrollment each year, you have the opportunity to select the medical plan option you want to use for the year. Your cost varies depending on which medical plan option and coverage level you select. This booklet explains which events during the year might allow you to add a dependent or otherwise modify your coverage.

For further information about your medical, pharmacy, and wellness program benefits, you may contact the Employee Benefits Service Center or the Administrators at the appropriate address below.

**MEDICAL CLAIMS ADMINISTRATOR**
Medica
401 Carlson Parkway
Minnetonka, MN 55305

Phone: 952-992-1814
Toll Free: 1-877-252-5558
TTY users, please call 711
Website: [www.medica.com/uofm](http://www.medica.com/uofm)

**WELLBEING PROGRAM ADMINISTRATOR**
RedBrick Health
10 S. Marquette Avenue, Suite 500
Minneapolis MN 55402

Phone: 844-724-8636
Access through [humanresources.umn.edu/wellbeingprogram](http://humanresources.umn.edu/wellbeingprogram) using your University Internet ID and password.

**PHARMACY BENEFITS MANAGERS**
Prime Therapeutics LLC
1405 Corporate Center Drive
Eagan, MN 55121

Phone: 1-800-727-6181
Website: [www.myprime.com](http://www.myprime.com)

Fairview Specialty Pharmacy
711 Kasota Avenue
Minneapolis, MN 55414

Phone: 612-672-5289
Toll Free: 1-877-509-5115
Website: [www.fairviewspecialtyrx.org/uplan](http://www.fairviewspecialtyrx.org/uplan)
Specific Information About the Plan

**Employer:** University of Minnesota

**Name of the Plan:** The Plan shall be known as the University of Minnesota UPlan Medical Program that provides medical benefits to certain eligible participants and their dependents.

**Address of the Plan:** University of Minnesota
Employee Benefits
200 Donhowe Building
319 15th Ave. SE
Minneapolis, MN 55455-0103

**Plan Year:** The Plan Year begins on January 1 and ends on December 31. A Plan Year is 12 months in duration.

**Plan Sponsor:** Board of Regents
600 McNamara Alumni Center
200 Oak Street SE
Minneapolis, MN 55455-2020

**Funding:** Claims under the Plan are paid from the assets of the University of Minnesota UPlan Medical Program.

**Medical Claims Administrator:** Medica
401 Carlson Parkway
Minnetonka, MN 55305

**Pharmacy Benefits Manager:** Prime Therapeutics LLC
1405 Corporate Center Drive
Eagan, MN 55121

Fairview Specialty Pharmacy
711 Kasota Avenue
Minneapolis, MN 55414

**Wellbeing Program Administrator:** RedBrick Health
10 S. Marquette Avenue, Suite 500
Minneapolis MN 55402
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<table>
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<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Care</strong>*</td>
<td>100% coverage</td>
<td>100% coverage</td>
<td>100% coverage</td>
<td>100% coverage**</td>
</tr>
<tr>
<td>Eye and Hearing Exam (routine)</td>
<td>100% coverage</td>
<td>100% coverage</td>
<td>100% coverage</td>
<td>100% coverage</td>
</tr>
<tr>
<td>Physician***</td>
<td>$25 Primary/ $35 Specialty copay</td>
<td>$20 Primary/ $30 Specialty copay</td>
<td>$40 Primary/ $50 Specialty copay</td>
<td>90% coverage after deductible</td>
</tr>
<tr>
<td>All Walk-in/ Convenience Clinics and Virtual Care****</td>
<td>$15 copay</td>
<td>$15 copay</td>
<td>$20 copay</td>
<td>90% coverage after deductible</td>
</tr>
<tr>
<td>Outpatient MRI and CT Scan</td>
<td>$50 copay</td>
<td>$40 copay</td>
<td>$50 copay</td>
<td>90% coverage after deductible</td>
</tr>
<tr>
<td>Urgent Care: In-Network and Out-of-Network</td>
<td>$25 copay</td>
<td>$20 copay</td>
<td>$40 copay</td>
<td>90% coverage after deductible</td>
</tr>
<tr>
<td>Emergency Care: In-Network and Out-of-Network</td>
<td>$100 copay, waived if admitted</td>
<td>$100 copay, waived if admitted</td>
<td>$100 copay, waived if admitted</td>
<td>90% coverage after deductible</td>
</tr>
<tr>
<td>Outpatient Mental Health/Substance Abuse</td>
<td>$25 copay</td>
<td>$20 copay</td>
<td>$40 copay</td>
<td>90% coverage after deductible</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>$25 copay</td>
<td>$20 copay</td>
<td>$40 copay</td>
<td>90% coverage after deductible</td>
</tr>
<tr>
<td>Physical, Speech, and Occupational Therapy</td>
<td>$25 copay</td>
<td>$20 copay</td>
<td>$40 copay</td>
<td>90% coverage after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>$25 copay</td>
<td>$20 copay</td>
<td>$40 copay</td>
<td>90% coverage after deductible</td>
</tr>
</tbody>
</table>

* Preventive care includes routine physical, hearing and eye exams; well child care; prenatal care; immunizations; and allergy injections.

**HSA guidelines do not view allergy injections as preventive; therefore, the deductible and coinsurance apply to this service.

*** Primary Care includes Family Medicine, Internal Medicine, Obstetrics/Gynecology, and Pediatrics.

**** Gopher Quick Clinic in the Twin Cities, WellCare in Duluth, and other walk-in/convenience care clinics; also applies to virtual care.
## Medical: Plan Comparison

### IN-NETWORK AND OUT-OF-NETWORK

<table>
<thead>
<tr>
<th>Deductibles and Services</th>
<th>Base Plan Medica Elect/Essential</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network Deductible</strong></td>
<td>$100 per person/ $200 per family</td>
<td>$100 per person/ $200 per family</td>
<td>$200 per person/ $400 per family</td>
<td>Total in-network and out-of-network: Employee only: $1,500 Family: $3,000</td>
</tr>
<tr>
<td><strong>Out-of-Network Deductible</strong></td>
<td>$600 per person/ $1,200 per family</td>
<td>$600 per person/ $1,200 per family</td>
<td>$600 per person/ $1,200 per family</td>
<td></td>
</tr>
<tr>
<td><strong>Lab/X-Ray</strong></td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>90% coverage after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>90% coverage after deductible</td>
</tr>
<tr>
<td><strong>In-Network Hospital (General and Mental Health/ SubSTANCE Abuse Care)</strong></td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>90% coverage after deductible</td>
</tr>
<tr>
<td><strong>Ground and Air Ambulance to Nearest Facility</strong></td>
<td>80% coverage</td>
<td>80% coverage</td>
<td>80% coverage</td>
<td>90% coverage after deductible</td>
</tr>
<tr>
<td><strong>Prosthetics, Durable Medical Equipment</strong></td>
<td>80% coverage, including hearing aids</td>
<td>80% coverage, including hearing aids</td>
<td>80% coverage, including hearing aids</td>
<td>90% coverage after deductible, including hearing aids</td>
</tr>
<tr>
<td><strong>Out-of-Network Care</strong></td>
<td>70% coinsurance after deductible is met, up to the annual out-of-pocket maximum</td>
<td>70% coinsurance after deductible is met, up to the annual out-of-pocket maximum</td>
<td>70% coinsurance after deductible is met, up to the annual out-of-pocket maximum</td>
<td>70% coinsurance after deductible is met, up to the annual out-of-pocket maximum</td>
</tr>
</tbody>
</table>

*In-network deductible applies to expenses without a copay, primarily in- and out-patient hospital, and lab/x-ray.
Medical: Plan Comparison

PRESCRIPTION DRUGS

The UPlan Pharmacy program is provided through Prime Therapeutics and Fairview Specialty Pharmacy. It is automatically provided to members in all UPlan medical options.

A prescription is dispensed as a 30-day supply (including insulin) in network pharmacies only.

<table>
<thead>
<tr>
<th>Prescription Drug Categories</th>
<th>Base Plan Medica Elect/ Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certain Preventive Medications Specified in the Affordable Care Act and Contraceptives in the Generic Plus Category</td>
<td>$0 copay</td>
<td>$0 copay</td>
<td>$0 copay</td>
<td>100%</td>
</tr>
<tr>
<td>Generic Plus (Tier 1) Drugs (includes all generic drugs and some low-cost brand drugs if there is no generic drug in a given therapeutic class)</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td></td>
</tr>
<tr>
<td>Formulary Brand Name (Tier 2) Drugs (includes all other formulary brand drugs)</td>
<td>$30 copay</td>
<td>$30 copay</td>
<td>$30 copay</td>
<td></td>
</tr>
<tr>
<td>Non-formulary (Tier 3) Drugs (includes covered brand drugs not listed on formulary)</td>
<td>$75 copay</td>
<td>$75 copay</td>
<td>$75 copay</td>
<td></td>
</tr>
<tr>
<td>Purchase of Brand Drug When Chemically Equivalent Generic is Available</td>
<td>Pay the generic copay and difference in cost* between the brand drug and the generic drug</td>
<td>Pay the generic copay and difference in cost* between the brand drug and the generic drug</td>
<td>Pay the generic copay and difference in cost* between the brand drug and the generic drug</td>
<td>Prescriptions are covered in the HSA and at 90% in medical plan after deductible**</td>
</tr>
<tr>
<td>Drugs Purchased by Mail Order</td>
<td>3-month supply available for two copays</td>
<td>3-month supply available for two copays</td>
<td>3-month supply available for two copays</td>
<td>90-day supply available at discount</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum (Rx only)</td>
<td>$750 per person/ $1,500 per family</td>
<td>$750 per person/ $1,500 per family</td>
<td>$750 per person/ $1,500 per family</td>
<td>No separate out-of-pocket maximum for prescriptions</td>
</tr>
</tbody>
</table>

* The difference in cost does not apply toward the annual out-of-pocket maximum.
** When in the coinsurance level, pay 10 percent coinsurance based on generic price in addition to difference in cost between the brand drug and the generic drug.
### OTHER COVERAGE AND MAXIMUMS

<table>
<thead>
<tr>
<th>Other Coverage and Maximums</th>
<th>Base Plan Medica Elect/Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Travel Benefit: In-Network Coverage</strong></td>
<td>For students and other travelers if services are provided by United Healthcare Options PPO providers</td>
<td>For students and other travelers if services are provided by United Healthcare Options PPO providers</td>
<td>For out-of-area residents, students and other travelers if services are provided by United Healthcare Options PPO providers</td>
<td>For out-of-area residents, students and other travelers if services are provided by United Healthcare Options PPO providers</td>
</tr>
<tr>
<td><strong>National Coverage</strong></td>
<td>Available through emergency or out-of-network benefit only</td>
<td>Available through emergency or out-of-network benefit only</td>
<td>Available in-network through United Healthcare Options PPO network</td>
<td>Available in-network through United Healthcare Options PPO network</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>$2,500 per person/ $4,000 per family</td>
<td>$2,500 per person/ $4,000 per family</td>
<td>$2,500 per person/ $4,000 per family</td>
<td>$3,000 per person/ $6,000 per family (Note: Out-of-pocket maximums include the deductible)</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

### HSA

<table>
<thead>
<tr>
<th>UPlan Contributions*</th>
<th>Employee Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee-only amount</td>
<td>$750</td>
</tr>
<tr>
<td>Catch-up amount - Age 55 or over</td>
<td>$1,500</td>
</tr>
<tr>
<td>Family coverage amount (either tier)</td>
<td>$1,500</td>
</tr>
<tr>
<td>Catch-up amount - Age 55 or over</td>
<td></td>
</tr>
</tbody>
</table>

*UPlan contributions can be used to offset deductibles.
I. Introduction to Your Medical and Pharmacy Coverage

The University of Minnesota ("Sponsor"), which also serves as sponsor of the plan, has established the UPlan ("the Plan") to provide medical benefits for covered contract holders and their covered dependents ("Members"). This Plan is “self-funded,” which means that the Sponsor pays the benefit expenses for covered services as claims are incurred. The Plan is described in this Summary of Benefits.

The Sponsor has contracted with Medica and Prime Therapeutics and Fairview Specialty Pharmacy to provide networks of health care providers and pharmacies, claims processing, precertification and other administrative services. However, the Sponsor is solely responsible for payment of your eligible claims.

The Sponsor, by action of an authorized officer or committee, reserves the right to change or terminate 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 decision to change the Plan may be due to changes in federal or state laws governing health and welfare benefits, or for any other reason. The Plan may be changed to transfer the Plan’s liabilities to another plan or to split this Plan into two or more parts.

The Sponsor has the power to delegate specific duties and responsibilities. Any delegation by the Sponsor may also allow further delegations by such individuals or entities to whom the delegation has been made. Any delegation may be rescinded by the 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.

A. Claims Administrators — Medical and Pharmacy
Medica, Prime Therapeutics, and Fairview Specialty Pharmacy provide certain administrative services in connection with the Plan. As external administrators, Medica, Prime Therapeutics, and Fairview Specialty Pharmacy are referred to as the "Claims Administrators." A Claims Administrator may arrange for additional parties to provide certain administrative services, including claim processing services, subrogation, utilization management, medical management, and complaint resolution assistance.

The Claims Administrator has the discretionary authority to determine a Member’s entitlement to benefits under the terms of the Plan, including the authority to determine the amount of payment for claims submitted and to constitute the terms of each Plan. However, the Claims Administrator may not make modifications or amendments to the Plan.

B. Rate Structure
The rate structure for the cost of medical benefits consists of employee-only coverage and two levels of family coverage that are determined by the eligible dependents added to the plan. The levels are:

» Employee only
» Employee and Children
» Employee and Spouse with or without Children
C. Summary of Benefits
This Summary of Benefits is your description of the UPlan. It describes the Plan’s benefits and limitations for your medical coverage. Please read this entire summary carefully. 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 the Summary of Benefits have special meanings; they are capitalized and are specifically defined in the Summary.

Included in this Summary is a Benefit Features chart that states the amount payable for the covered services. Amendments that are included with this Summary or sent to you at a later date are fully made a part of this Summary of Benefits. This Plan is maintained exclusively for covered participants and their covered dependents. Each Member’s rights under the Plan are legally enforceable. The Summary of Benefits (and any amendments) is available to view and download on the Employee Benefits website at humanresources.umn.edu/employee-benefits/medical.

D. Your Identification Card
Your medical and pharmacy Claims Administrators issue separate identification cards to Members containing coverage information. Please verify the information on the ID card and notify the Claims Administrator’s Customer Service department of any errors.

When you receive your ID card, review the card to make sure the correct plan is listed on the card. If you are in Medica Elect/Essential, make sure that the correct PCC (Primary Care Clinic) is listed. If your plan or PCC is not correct, please contact the Claims Administrator’s Customer Service department immediately. If you receive services at another location, it may result in ineligible claims.

Social Security numbers are considered private and confidential. The Claims Administrators do not use your Social Security number on your ID card. However, for all Claims Administrators, the Social Security numbers are required for claims processing.

Your name may be abbreviated due to space limitations, but it is important that your identification card is correct or claims may be delayed or temporarily denied. Contact the Claims Administrator’s Customer Service department if the clinic information is incorrect. Contact the University of Minnesota Employee Benefits department for any other corrections.

You must show your medical ID card every time you request medical care services from participating providers and your pharmacy ID card when obtaining retail prescription drugs. If you do not show your card, the participating provider has no way of knowing you are a Member and may bill you for the services.

E. Provider Directory
To access the most up-to-date information on participating providers and facilities, go to Medica’s website at www.medica.com/uofm. You will find an online provider finder and other search tools on the plan’s website.

F. Conflict with Existing Law
In the event that any provision of this Summary of Benefits is in conflict with applicable law, only that provision is hereby amended to conform to the minimum requirements of the law.

G. Records
Certain facts are needed for plan administration, claims processing, utilization management, quality assessment, and case management. By enrolling for coverage under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Sponsor or any of its agents or designees at any reasonable time, upon its request, any and all information and records or copies of records relating to the services provided to you.
I. Introduction to Your Medical and Pharmacy Coverage

The Sponsor or its agents or designees will have the right to release any and all records concerning health care services that are necessary to implement and administer the terms of the Plan or for appropriate medical review or quality assessment. The Sponsor and its agents or designees will maintain confidentiality of such information in accordance with existing law. This authorization applies to you and each dependent, regardless of whether each dependent signs the application for enrollment.

For information on privacy practices, refer to XVIII. Notice of Privacy Practices.

H. Transition of Care
Employees and dependents who are in the midst of treatment for a serious medical condition may need special assistance to change to a new medical plan. Transition of care allows for a short-term continuation with your current provider before you begin receiving care from a provider in your new medical plan’s network. The plans’ care coordinators will work with your medical providers when you are receiving treatment for one of the following conditions or situations:

» An acute condition, or
» A life-threatening mental or physical illness, or
» Pregnancy once confirmed by a physician, or
» 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 one year, or can be expected to result in death, or
» A disabling or chronic condition that is in an acute phase, or
» The member is receiving culturally appropriate services and Medica does not have a provider in its provider network with special expertise in the delivery of those culturally appropriate services within the time and distance requirements, or
» The member does not speak English and Medica does not have a provider in its network that can communicate with the member either directly or through an interpreter within the time and distance requirements

A current course of treatment is defined as having received consultation or treatment from a provider for a specific condition within 90 days prior to your effective date with Medica. Each request will be reviewed and decided by Medica after consideration of the factors such as the reason for the request and length of time and scope of services involved in the request. The care coordinators at Medica will assist you with completing the form and other steps for short-term continuation with your current provider.

I. Clerical Error
You will not be deprived of coverage under the Plan because of a clerical error. However, you will not be eligible for coverage beyond the scheduled termination of your coverage because of a failure to record the termination.

J. Claims Filing
If you received services from Nonparticipating Providers, you may have to submit the claims yourself. Claims should be filed as soon as documentation is available, but no later than 18 months after the date of service. You must submit an itemized bill that documents the date and type of service, provider name, and charges for the services incurred. Your plan membership number must be on the claim. The Plan may request that additional information be submitted, as needed, to make a claim determination.

You must submit claims in English along with the Plan’s claim form and send it to the appropriate address below:

Medica Self Insured
PO Box 30990
Salt Lake City, UT 84130

Prime Therapeutics LLC
P.O. Box 14527
Lexington, KY 40512-4430
II. Coverage Eligibility and Enrollment

A. Eligibility

The University of Minnesota develops eligibility criteria for its employees and their dependents subject to collective bargaining agreements and compensation plans that may change during a Plan Year. Employees are eligible to participate in the University of Minnesota UPlan Medical Program (the Plan) if all three criteria are met:

1) The appointment is in an eligible classification;
2) The appointment is 50% time or greater;
3) The appointment will last for three months or longer.

The University contributes a significant portion of the cost of medical benefits for an employee with an appointment of 75% time or greater. If the employee's appointment is 50% to 74% time, the employee is eligible to participate in the Plan but must pay full cost of coverage; there is no University contribution at this level of employment.

In no event can a person receive coverage as both an employee and as a dependent of another UPlan member. For example, you may not have coverage for yourself as an employee and be a dependent on the coverage of a spouse or a parent who has family coverage as a University of Minnesota employee.

In no event can an employee include a dependent on the Plan who is ineligible for coverage. (See O. Misuse of Plan.) The Plan reserves the right to request documentation to verify eligibility of your enrolled dependents.

1. Definition of Eligible Dependents

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

**Definition of eligible dependents**
The chart specifies the criteria for coverage along with whether the dependent is considered qualified for favorable tax treatment under the Plan.

<table>
<thead>
<tr>
<th>Relationship to Employee</th>
<th>Criteria for Coverage</th>
<th>Is Dependent Qualified for Tax Favored Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Spouse</strong></td>
<td>Must be legally married. Your spouse must not be working full-time for an employer and receiving cash or credits 1) in place of medical coverage or 2) in exchange for medical coverage with a deductible of $750 or greater.</td>
<td>Qualified</td>
</tr>
<tr>
<td><strong>Dependent Child</strong></td>
<td>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 be treated as a dependent. Note: The spouse of your eligible married dependent child is not eligible for coverage.</td>
<td>Qualified</td>
</tr>
<tr>
<td></td>
<td>Disabled child— age 26 or above (no maximum) if physically or mentally disabled and either: • lives with you and does not provide over 50% of his/her own support, or • does not live with you but is at least 50% dependent on you</td>
<td>Qualified</td>
</tr>
<tr>
<td><strong>Dependent Grandchild</strong></td>
<td>Grandchild as dependent child — A grandchild is eligible for coverage as your child if placed in your legal custody; or if the grandchild is legally adopted or placed with you for the purpose of adoption. Additional grandchildren eligibility — An unmarried grandchild is also eligible under the Plan for coverage if (1) the grandchild is dependent upon you for principal support and maintenance, but is a qualified tax dependent of another person or (2) your unmarried grandchild is the dependent child of your unmarried dependent child, and even though the grandchild may be dependent upon you for principal support and maintenance, the grandchild would not be eligible to be your tax dependent under tax regulations. In these instances, the contributions made by the University to your grandchild’s coverage as well as your contributions are considered taxable income on your tax returns. Newborns — Your newborn infant grandchild is eligible under the Plan for coverage if the grandchild is financially dependent upon you and resides with you continuously from birth. Coverage for the grandchild may terminate if the grandchild does not continue to reside with you continuously, if the grandchild does not remain financially dependent upon you, or when the grandchild reaches age 25.</td>
<td>Qualified</td>
</tr>
</tbody>
</table>

1 “Tax Favored Treatment” refers to how dependent coverage is treated for tax purposes.
2. Tax Favored and Non-Tax Favored Treatment of Dependent Coverage
   a) If the right-hand column is marked “Qualified” for a given dependent category, it means you will pay pre-tax contributions for yourself and any dependents. It also means that the value of the University’s contribution to the plan is not considered taxable income to you as the employee.

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

   b) If the right-hand column is marked “Non-qualified” for a given dependent category, it means that you will be taxed on the value of the University’s contribution for your non-qualified dependent’s coverage. This taxable value is called imputed income.

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

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

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

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

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

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

3. Eligible Dependent Children
   a) An eligible child, unmarried or married, can include your own biological child, legally adopted child, or child placed for the purposes of adoption, foster child, stepchild, and any other child state or federal law requires be treated as a dependent.

   i) For a child who is being adopted, the date of placement means the date you assume and retain the legal obligation for total or partial support of the child in anticipation of your adoption of the child. A child’s adoption placement terminates upon the termination of the legal obligation of total or partial support.

   ii) To be considered a dependent child, a foster child must be placed by the court in your custody.

   iii) To be considered a dependent child, a stepchild must be the child of your spouse by a previous marriage or relationship.
II. Coverage Eligibility and Enrollment

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

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

c) **Grandchild as dependent child** — A grandchild is eligible for coverage as your child if placed in your legal custody; or if the grandchild is legally adopted or placed with you for the purpose of adoption.

**Additional grandchildren eligibility** — An unmarried grandchild is also eligible under the Plan for coverage if (1) the grandchild is dependent upon you for principal support and maintenance, but is a qualified tax dependent of another person or (2) your unmarried grandchild is the dependent child of your unmarried dependent child, and even though the grandchild may be dependent upon you for principal support and maintenance, the grandchild would not be eligible to be your tax dependent under tax regulations. In these instances, the contributions made by the University to your grandchild’s coverage as well as your contributions are considered taxable income on your tax returns.

**Newborns** — Your newborn infant grandchild is eligible under the Plan for coverage if the grandchild is financially dependent upon you and resides with you continuously from birth. Coverage for the grandchild may terminate if the grandchild does not continue to reside with you continuously, if the grandchild does not remain financially dependent upon you, or when the grandchild reaches age 25.

4. Eligibility of Spouse

If both you and your spouse work for the University of Minnesota, then either of you has the option of adding the other as a dependent to family coverage. The spouse added to the family coverage must waive employee coverage.

If your spouse works full-time for an employer and receives cash or credits (1) in place of medical coverage, or (2) in exchange for a medical coverage with a deductible of $750 or greater, then your spouse is not considered to be an eligible dependent under the Plan.

Call 612-624-8647 or 800-756-2363 to reach the Employee Benefits Service Center.

5. Coverage of Disabled Children of Any Age

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

b) A dependent child must be certified by the UPlan Medical Claims Administrator to be disabled prior to age 26, based on proof that the child meets the above requirements.

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

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

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

i) You (the employee) enroll for coverage during your initial eligibility period, and;
II. Coverage Eligibility and Enrollment

ii) The UPlan Medical Claims Administrator certifies that the dependent meets the above requirements. Proof of disability status must be provided within 31 days of your initial date of eligibility and enrollment in the Plan. The disabled dependent shall be eligible for coverage as long as he/she continues to be disabled and dependent, unless coverage otherwise terminates under the Plan.

A dependent child who is considered to be disabled by the UPlan Medical Claims Administrator will be eligible for tax favored coverage under the Plan, regardless of age.

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

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

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

Family status changes include:
- Change in legal marital status, including marriage, divorce, or annulment.
- Death of your spouse or last eligible dependent child.
- Birth or adoption of your eligible dependent child.
- Change in last dependent child’s eligibility because of age.
- Commencement or termination of employment for you, spouse, or dependent.
- Changes in your or your spouse’s employment status from part time to full time or from full time to part time.
- Change in the place of residence or worksite for you, spouse, or dependent to a location outside of the current plan’s service area and the current plan is not available.

Call Employee Benefits if you have more specific questions about changes in your coverage.

9. Dependent Eligibility Verification
The University has a responsibility to ensure UPlan resources are well managed and to apply the dependent eligibility rules fairly and equally. For both these reasons, you will be asked to verify eligibility of your dependents if they are added to your UPlan coverage when you are a new employee, when you acquire a new dependent, or during Open Enrollment.

You will need to verify the eligibility of these dependents by providing documentation such as a tax form, marriage certificate, or a birth or adoption certificate.

Please respond to the verification request from Employee Benefits promptly to ensure coverage for your dependents.
II. Coverage Eligibility and Enrollment

B. Effective Date of Coverage
1. The initial effective date of coverage is the first day of the month following the first day of employment, newly benefits-eligible position, reemployment, or reinstatement. You must be actively at work on the initial effective date of coverage, or coverage will be delayed until the first day of the payroll period following the date the employee returns to active payroll status. However, if you are not actively at work on the initial effective date of coverage due to your health status, medical condition, or disability, or that of your dependent, as such terms are defined in Section 9802(a) of the Internal Revenue Code and related regulations, coverage shall not be delayed.

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

3. A newborn child’s coverage takes effect from the moment of birth.

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

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

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

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

D. Initial Enrollment
1. You must complete your enrollment for yourself and any eligible dependents within 30 days of date of hire or from the date you first become eligible, if currently employed. Payroll deductions will be based on your effective date of coverage not on the date your enrollment was completed. Failure to enroll within 30 days will result in no coverage for you and any eligible dependents. However, you will be permitted to enroll at the next Open Enrollment or sooner in the event of a qualified change in family status (see G. Midyear Enrollment Due to Status Change).

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

E. Waiting Period Medical Coverage
You may purchase medical coverage for the waiting period from your first day of employment until your active coverage begins. You may elect a medical plan, other than Medica HSA, for this coverage. You need to enroll within 30 days of your first day of employment and pay the full cost of the coverage for the full waiting period. Please contact the Employee Benefits Service Center at 612-624-8647 or 800-756-2363. You may elect a different plan and coverage level when you enroll online for your active coverage.
II. Coverage Eligibility and Enrollment

F. Open Enrollment
During the University of Minnesota UPlan annual Open Enrollment period you may change medical plans, enroll in coverage for yourself, waive coverage, and add or drop dependents from your coverage for the upcoming plan year.

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

You may add coverage within your selected UPlan medical plan option for all eligible dependents within 30 calendar days of the following events:

1. You legally marry.
2. If your dependent spouse loses group coverage, you may add family coverage. Loss of coverage includes any change in coverage that results in termination of your dependent’s coverage, even if it is immediately replaced by other subsidized coverage.

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

Loss of coverage does not include the following:

a) A change in Medical Claims Administrators through the same employer where the coverage is continuous and uninterrupted;

b) A change in your dependent’s medical plan benefit levels; and

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

3. When you acquire a dependent child. In addition, at this time you can add your spouse and any other eligible dependent children who have not been covered under the UPlan.

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

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

1. Any Claims Administrator participating in the University of Minnesota UPlan Medical Program is placed into reorganization or liquidation or is otherwise unable to provide the services specified in the Summary of Benefits.

2. Any Claims Administrator participating in the University of Minnesota UPlan Medical Program loses all or a portion of its primary care provider network (including Hospitals) to the extent that primary care services are not accessible or available within 30 miles of your work location or residence.

3. Any Claims Administrator participating in the University of Minnesota UPlan Medical Program terminates or is terminated from participation in the UPlan.

4. The University of Minnesota approves a request from an employee due to an administrative error that occurs during the open enrollment process.
II. Coverage Eligibility and Enrollment

5. An enrollee moves or is transferred to a location outside of the current plan’s service area and the enrollee’s current plan is not available.

6. Retirees may elect to change to another UPlan medical plan in the 60 days immediately preceding the effective date of retirement.

I. Adding New Dependents

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

1. Adding a spouse.
   A spouse is eligible on the date of legal marriage.

   You must complete enrollment within 30 days after the legal marriage for coverage to become effective on the date of legal marriage. Deductions for the appropriate level of family coverage will begin with the first day of the payroll period that includes the date of legal marriage.

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

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

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

J. HIPAA Special Enrollment Rights Changes

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

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

K. ACA Special Enrollment

The employee is eligible to participate in UPlan Medical coverage for one year, under guidelines of the Affordable Care Act (ACA), if he/she was not originally an eligible participant, but has worked 30 hours or more per week on average during the past year. Eligibility for this coverage is determined once a year for all employees who have worked over a year. Eligibility for employees who have recently completed one year of service is determined on a monthly basis. Each employee will be notified in writing if he/she becomes eligible under ACA guidelines. The employee will need to continue to work 30 hours or more per week on average in future years to remain eligible for ACA coverage for the following year.
II. Coverage Eligibility and Enrollment

L. Waive Coverage
You have the option as a new employee and during Open Enrollment to waive coverage, which means you do not have coverage, or to decrease medical coverage.

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

- Your legal marriage terminates
- You gain medical coverage through your spouse
- You experience a significant change in employer contributions
- You move to a new location outside of your current plan’s service area and your current plan is not available
- You retire
- Your work appointment decreases to fewer than 30 hours per work
- You elect to enroll in state exchange coverage

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

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

- Your legal marriage
- The birth or adoption of your child
- The death of your spouse or last dependent child
- Your divorce
- You lose coverage through your spouse
- You experience a significant change in employer contributions
- Your dependent child to age 26 meets eligibility criteria as stated in the chart in A. Eligibility

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

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

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

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

5. For a child covered as a dependent, the last day of the month in which the child is no longer eligible as a dependent. Coverage terminates on the last day of the month in which a dependent turns age 26.

6. For a dependent, the effective date of coverage, if the employee or his/her dependent knowingly makes fraudulent misstatements regarding the eligibility of the dependent for coverage.

7. For an enrollee who is directly billed by the University of Minnesota, the last day of the month for which the last full payment was received, if the enrollee fails to make full payment within 30 days of the date the bill was due, whichever is later.

8. For any enrollee who is directly billed by the Claims Administrator and/or COBRA Administrator, the last day of the month for which the last payment was received, if the enrollee fails to make full payment within 30 days of the date the bill was due. Enrollees include COBRA participants, disabled participants, and retirees under age 65.

9. For a retiree and/or dependent over age 65 who terminates Medicare Part B Coverage, or who fails to apply for Medicare Part B Coverage within 30 days of the effective date of retirement, within 30 days after the retiree or dependent receives notice from the Claims Administrator.

In the event you no longer meet eligibility requirements, but your coverage has inadvertently been continued, the date of coverage termination depends on whether the employee contribution payments have been made.

a) If no or inadequate employee contribution payments have been made (including failure to make full continuation contribution payments for ineligible dependents), the coverage will be retroactively terminated to the date of loss or lack of eligibility.

b) If full employee contribution payments have been made (including full continuation contribution payments), the University of Minnesota UPlan may terminate coverage prospectively.

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

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

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

c) fail to notify Employee Benefits on a timely basis of loss of eligibility for your dependents; or

d) provide false, incorrect or fraudulent information on your enrollment, including your enrollment of dependents, as well as on the Dependent Eligibility Verification request from the University.
II. Coverage Eligibility and Enrollment

P. Certificate of Creditable Coverage
When you or your dependents terminate coverage under the Plan, a certification of creditable coverage form will be issued to you from your Claims Administrator specifying your coverage dates under the medical plan and any probationary periods you are required to satisfy. The certification of creditable coverage form will contain all the necessary information another medical plan will need to determine that you no longer have other coverage. Medical plans may require that you submit a copy of this form when you apply for coverage.

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

Q. Continuation
You or your covered dependents may continue coverage under this Plan if current coverage ends because of any of the qualifying events listed on the following page. You or your dependent must be covered under the Plan before the qualifying event in order to continue coverage. In all cases, continuation ends if the UPlan ends or required charges are not paid when due.

The following section generally describes continuation coverage under this Plan. Also refer to XX. COBRA Notice for more information.
II. Coverage Eligibility and Enrollment

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Who May Continue</th>
<th>Maximum Continuation Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment ends, certain leaves of absence, layoff, or reduction in hours</td>
<td>Employees and dependents</td>
<td>Earlier of:</td>
</tr>
<tr>
<td>(except gross misconduct dismissal)</td>
<td></td>
<td>» Enrollment date in other group coverage, or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>» 18 months</td>
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<tr>
<td>Divorce</td>
<td>Former spouse and any dependent children who lose coverage</td>
<td>Earlier of:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>» 36 months from the date of divorce</td>
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<tr>
<td></td>
<td></td>
<td>» Enrollment in other group coverage, or</td>
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<tr>
<td></td>
<td></td>
<td>» Date coverage would otherwise end</td>
</tr>
<tr>
<td>Death of employee</td>
<td>Surviving spouse and dependent children</td>
<td>Earlier of:</td>
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<tr>
<td></td>
<td></td>
<td>» Enrollment date in other group coverage, or</td>
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<tr>
<td></td>
<td></td>
<td>» Date coverage would otherwise end</td>
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<tr>
<td>Dependent child loses eligibility</td>
<td>Dependent child</td>
<td>Earlier of:</td>
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<tr>
<td></td>
<td></td>
<td>» 36 months from the date of losing eligibility, or</td>
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<td></td>
<td></td>
<td>» Enrollment in other group coverage, or</td>
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<tr>
<td></td>
<td></td>
<td>» Date coverage would otherwise end</td>
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<tr>
<td>Employee retires at age 65 or over and enrolls in Medicare Part A, Part B, or</td>
<td>Employee and dependents</td>
<td>Earliest of:</td>
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<tr>
<td>both</td>
<td></td>
<td>» 36 months from date of enrollment in Medicare</td>
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<td>» Enrollment in other group coverage, or</td>
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<td></td>
<td></td>
<td>» Date coverage would otherwise end</td>
</tr>
<tr>
<td>Surviving dependent of retiree on lifetime continuation due to bankruptcy of</td>
<td>Surviving spouse and dependents</td>
<td>36 months following retiree’s death</td>
</tr>
<tr>
<td>Employer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total disability*</td>
<td>Employee and dependents</td>
<td>Earlier of:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>» Date total disability ends, or</td>
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<tr>
<td></td>
<td></td>
<td>» Date coverage would otherwise end</td>
</tr>
<tr>
<td>Total disability of dependent**</td>
<td>Dependent</td>
<td>Earliest of:</td>
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<tr>
<td></td>
<td></td>
<td>» 18 months, or</td>
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<td></td>
<td></td>
<td>» 29 months after the employee leaves employment, or</td>
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<tr>
<td></td>
<td></td>
<td>» Date total disability ends, or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>» Date of enrollment in Medicare, or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>» Date coverage would otherwise end</td>
</tr>
</tbody>
</table>
II. Coverage Eligibility and Enrollment

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

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

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

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

1. Choosing continuation

If you lose coverage, the Plan will notify you within 14 days after employment ends of the option to continue coverage. If coverage for your dependent ends because of divorce or any other change in dependent status, you or your covered dependents must notify Employee Benefits in writing within 30 days after the qualifying event occurs.

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

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

Charges for continuation are the UPlan group rate plus a two-percent (2%) administration fee. (If the qualifying event for continuation is the employee’s total disability, the administration fee is not required.) All charges are paid according to the instructions in the COBRA and State Continuation Coverage form.

2. Additional qualifying events

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

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

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

3. Cost verification

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

4. Coverage after continuation

You and your dependents should be able to access coverage through the state or federal insurance exchanges (www.mnsure.org or HealthCare.gov) after your continuation coverage ends.

R. Choosing a Medical Plan

Eligible employees and their dependents may select a medical plan based upon either work location or where they live. However, if you select an Accountable Care Organization (ACO), you and your dependents must live in one of the counties in the ACO’s service area. There may be other options that you can choose, but they have limited provider availability.

All other enrollees (disabled, COBRA, and early retirees) may choose a medical plan based upon where they live.

S. Employees Whose Permanent Work Location is Outside of Minnesota

Designated employees whose permanent work location is out of the state of Minnesota and surrounding border communities may self-refer to any licensed provider and receive in-network base plan benefits.

Employee Benefits must have notification from the employee’s department to verify that the employee works out of state for the University. Contact Employee Benefits if there are any questions on the benefits.

T. Employees Whose Children Reside Out-of-Area with an Ex-Spouse

Children residing out of the service area with an ex-spouse may receive services from any licensed provider in the area in which they reside at the same benefit level of the employee’s coverage. This benefit also applies to children living out of the service area with the other biological parent.

If children qualify for this benefit, contact Employee Benefits to complete a form to designate this special coverage. If the ex-spouse is covered by the same UPlan option, he/she would have out-of-area benefits consistent with the employee’s medical plan and is not eligible for this additional benefit.

U. Retirement

An employee covered by the UPlan who is retiring from the University at age 55 or older with five years of service, age 50 to 54 with 15 years of service, or regardless of age with 30 years of service, who is eligible to maintain participation in the UPlan may maintain health coverage with the University.

Employees retiring under age 65 make a selection from the UPlan options, while retirees over age 65 must elect a University of Minnesota over-65 retiree medical plan which incorporates Medicare benefits. Individuals on a University separation program, meeting the above criteria, are eligible to continue in the UPlan regardless of age. The employee must complete the proper forms with the University preferably before retirement but within 30 days after the effective date of retirement.

If a retiring employee fails to make a proper election within the 30-day time period, the retiring employee may continue coverage for up to 18 months in accordance with state and federal law. See item Q. Continuation for information on your continuation rights. In any event, failure to pay the premium will result in termination of coverage. Once coverage has been terminated for any reason, voluntary or involuntary, the retiree, early retiree, and the dependents may not rejoin the University of Minnesota UPlan.
Retirees and dependents over age 65 must apply for Medicare Part B coverage within 30 days of the effective date of retirement in order to continue coverage in the UPlan retiree group. Medicare will then become primary.

V. Long-Term Disability
An employee covered by the UPlan who is approved under a University-sponsored Long-Term Disability program may maintain health coverage with the University by paying the full cost. An employee on disability who becomes eligible for Medicare may elect a University of Minnesota over-65 retiree medical plan that incorporates Medicare benefits. When disability status ceases, the individual may continue health coverage for the remainder of the COBRA entitlement period, which runs concurrently with the benefits extended under this program in accordance with state and federal law. See item Q. Continuation for information on your continuation rights. However, the employee may maintain health coverage indefinitely with the University under the University Retiree Program provided that the retirement age and service requirements are met. In any event, failure to pay the premium will result in termination of coverage.

Employees over age 65 must have Medicare Part B coverage in place prior to transferring to the over age 65 retiree/disability group at the carrier. Medicare will then become primary.
III. Plan Descriptions

A. Medica Elect/Essential
Medica Elect/Essential combines two provider networks that include 20 major health care systems in the Twin Cities and Duluth areas. When you join Medica Elect/Essential, you will need to select a primary care clinic (PCC). Family members may select their own primary care clinics. You and your family members can choose separate primary care clinics from care systems in either the Elect or Essential networks.

The clinic you choose determines your designated care system. A care system is a comprehensive network of health care providers who work together to provide health care services. Each care system includes primary care physicians and affiliated specialists, clinics, hospitals, other health professionals, and a variety of other health facilities and programs.

1. Plan Availability
Medica Elect/Essential is the base plan for the Twin Cities Metro Area. It is available to you if you live or work in one of these counties:
   • Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Kanabec, McLeod, Ramsey, Scott, Sherburne, Washington, and Wright in Minnesota
   • Pierce and St. Croix in Wisconsin

Medica Elect/Essential is also the base plan for the Duluth Area. It is available to you if you live or work in one of these counties:
   • Northern half of Carlton, Lake, and St. Louis in Minnesota
   • Douglas, Sawyer, and Washburn in Wisconsin

2. How to Access a Provider Directory
The most up-to-date participating provider information can be accessed on Medica’s website at www.medica.com/uofm. If you need additional information, call Medica Customer Service at 952-992-1814 or 1-877-252-5558 or register at myMedica.com to get personalized information.

3. Changing Clinics
During the year, you can change your clinic selection by calling Medica Customer Service at 952-992-1814 or 1-877-252-5558 by the 20th of the month. Your clinic change will be effective the first day of the following month.

4. Referrals
Each care system establishes its own access procedures for seeing specialists. Some require a referral from your primary care physician while others allow you to directly access a specialist affiliated with your designated care system. You must follow your care system’s access procedures to receive the highest level of benefits. You need Medica’s approval to receive the highest level of benefits if referred to an out-of-network provider.

5. Out-of-Network Services
When you do not follow your care system’s access procedures or you receive services outside the service area from a nonparticipating provider, your care is considered “out-of-network” and covered at the coinsurance level after the deductible until the out-of-pocket maximum is met. However, the Travel Program provides in-network coverage when students and other travelers receive eligible services from UnitedHealthcare Options PPO providers.

6. Out-of-Area Coverage
Emergency medical care and urgent medical care received anywhere in the world is covered. Out-of-network emergency services including emergency ambulance, emergency room visits, emergency hospital admissions, and urgent care will be covered at the in-network benefit levels.
B. Medica Choice Regional
When you join Medica Choice Regional, you may seek medical care from any provider, including specialists, who participate in the statewide Medica Choice network with over 13,000 physicians and over 200 hospitals. You do not need to specify a primary care clinic when you enroll.

1. Plan Availability
Medica Choice Regional is the base plan for Greater Minnesota. It is available to you if you live or work in one of these counties:
   • Southern half of Carlton and remaining 71 counties; includes Crookston, Morris, and Rochester campuses in Minnesota
   • Burnett and Polk in Wisconsin

1. How to Access a Provider Directory
The most up-to-date participating provider information can be accessed on Medica’s website at www.medica.com/uofm. If you need additional information, call Medica Customer Service at 952-992-1814 or 1-877-252-5558 or register at myMedica.com to get personalized information.

2. Changing Clinics
You can change clinics at any time to a new provider who is a member of the Medica Choice network. You are encouraged to establish a close working relationship with a physician or primary care clinic in order to provide better coordination of your overall health needs.

3. Referrals
You may seek any participating network provider or specialist without a referral. However, it is important to confirm with the provider or with Medica that the provider participates in the network at the time you receive health care services. Anytime you receive care from a participating provider, your care is considered “in-network” and eligible services are covered.

4. Out-of-Network Services
When you do not follow your care system’s access procedures or you receive services outside the service area from a nonparticipating provider, your care is considered “out-of-network” and covered at the coinsurance level after the deductible until the out-of-pocket maximum is met. However, the Travel Program provides in-network coverage when students and other travelers receive eligible services from UnitedHealthcare Options PPO providers.

5. Out-of-Area Coverage
Emergency medical care and urgent medical care received anywhere in the world is covered. Out-of-network emergency services including emergency ambulance, emergency room visits, emergency hospital admissions, and urgent care will be covered at the in-network benefit levels.
III. Plan Descriptions

C. Medica ACO Plan
The Accountable Care Organization (ACO) Plan is a group of physicians, hospitals, and other care providers working together to coordinate patients’ health care in a way that improves both health and the patient experience. ACOs provide comprehensive health care and proactive health support for members.

1. Plan Availability
Medica ACO Plan is available to you if you live or work in one of the counties in their service area.

Twin Cities 13-county metro area
- Your ACO options are:
  - VantagePlus with Medica (Fairview, HealthEast, and North Memorial networks and Boynton Health and University of Minnesota Physicians);
  - Park Nicollet First with Medica; and
  - Ridgeview Community Network powered by Medica

Southern Minnesota and western Wisconsin
Your ACO option is Medica Complete Health (featuring care at Mayo Clinic)

Northern Minnesota, eastern North Dakota, and northwestern Wisconsin
Your ACO option is Essentia Choice Care with Medica.

Northwestern Minnesota and northeastern North Dakota
Your ACO option is Altru & You with Medica.

2. How to Access a Provider Directory
The most up-to-date participating provider information can be accessed on Medica’s website at www.medica.com/uofm. If you need additional information, call Medica Customer Service at 952-992-1814 or 1-877-252-5558 or register at myMedica.com to get personalized information.

3. Changing Clinics
During the year, you cannot change your ACO network. However, you can change clinics to a new provider who is a member of the ACO network. You are encouraged to establish a close working relationship with a physician or primary care clinic in order to provide better coordination of your overall health needs.

4. Referrals
You may see any participating provider or specialist in the ACO network without a referral. Anytime you receive care from a participating provider, your care is considered “in-network” and eligible services are covered. You need Medica’s approval to receive the highest level of benefits if referred to an out-of-network provider.

5. Out-of-Network Services
When you do not follow your ACO network’s access procedures or receive services outside the service area from a nonparticipating provider, your care is considered “out-of-network” and covered at the coinsurance level after the deductible until the out-of-pocket maximum is met. However, the Travel Program provides in-network coverage when students and other travelers receive eligible services from UnitedHealthcare Options PPO providers who are located outside of Medica’s service area.

6. Out-of-Area Coverage
Emergency medical care and urgent medical care received anywhere in the world is covered. Out-of-network emergency services including emergency ambulance, emergency room visits, emergency hospital admissions, and urgent care will be covered at the in-network benefit levels.
D. Medica Choice National
When you join Medica Choice National, you may seek medical care from any provider, including specialists, who participate in the statewide Medica Choice network with over 13,000 physicians and over 200 hospitals. You also have national coverage access to more than 659,000 physicians and health care providers through United Healthcare Options PPO network when outside the service area. You do not need to specify a primary care clinic when you enroll.

1. Plan Availability
Medica Choice National is available statewide and nationwide.

2. How to Access a Provider Directory
The most up-to-date participating provider information can be accessed on Medica’s website at www.medica.com/uofm.
If you need additional information, call Medica Customer Service at 952-992-1814 or 1-877-252-5558 or register at myMedica.com to get personalized information.

3. Changing Clinics
You can change clinics at any time to a new provider who is a member of the Medica Choice network. You are encouraged to establish a close working relationship with a physician or primary care clinic in order to provide better coordination of your overall health needs.

4. Referrals
You may see any participating network provider or specialist without a referral. However, it is important to confirm with the provider or with Medica that the provider participates in the network at the time you receive health care services. Anytime you receive care from a participating provider, your care is considered “in-network” and eligible services are covered.

5. Out-of-Network Services
When you receive services outside the Medica service area (Minnesota, North and South Dakota and western Wisconsin) from a non-participating provider, your care is considered “out-of-network” and covered at the coinsurance level after the deductible until the out-of-pocket maximum is met. If you need services outside the Medica service area you may use a national network or providers through the United Healthcare Options PPO network and receive in-network benefits. For a complete listing of providers within these networks, log on to www.medica.com/uofm or call Customer Service.

6. Out-of-Area Coverage
Emergency medical care and urgent medical care received anywhere in the world is covered. Out-of-network emergency services including emergency ambulance, emergency room visits, emergency hospital admissions, and urgent care will be covered at the in-network benefit levels.

E. Medica HSA
When you enroll in Medica Health Savings Account (HSA), you may seek medical care from any provider in the statewide Medica Choice network with over 13,000 physicians and more than 200 hospitals. When outside the service area, national coverage through United Healthcare Options PPO network gives you access to more than 659,000 health care providers. You do not need to indicate a primary care clinic when you enroll.

Due to federal law, if you have any other medical coverage, such as any part of Medicare, or you are on a spouse’s plan that is not a high deductible health plan, you are not eligible to enroll in Medica HSA.

However, if you are age 65 or older and delay taking Social Security benefits and Medicare Part A, you remain eligible.
Medica HSA is a high deductible health plan that allows you to make decisions about how you spend your health care dollars. The University contributes a set amount of tax-free benefits dollars to your HSA account to offset the deductible. After the deductible is satisfied, the plan pays 90%. However, your in-network preventive care—your routine physical, hearing and eye exams, well child care, prenatal care, and immunizations—is covered at 100%.

When enrolling mid-year, the HSA amount will be prorated per pay period; however, the deductible amount is not prorated. The amount you receive depends on when your coverage becomes effective. The amount is contributed over the number of pay periods remaining in the year. While the HSA amount is tax-sheltered from federal and state taxes in most states (including Minnesota), for federal reporting purposes the amount the University contributes to your HSA will be shown on your pay statement.

Enrollment in Medica HSA means that you are not eligible to fully participate in a health care flexible spending account. You may only use the pre-tax FSA plan to cover out-of-pocket costs for eligible dental and vision expenses.

You will have a special debit card to spend HSA dollars for pharmacy or medical expenses. You pay the doctor or pharmacy until the annual deductible is met, and then you can be reimbursed from the benefit account as funds are available. You own the HSA contributions and can decide whether to use them for current expenses or let the funds grow to cover medical expenses in retirement. You can also make your own pre-tax contributions to the HSA and invest them in options from Optum Bank. If you leave the University the account balances are portable.

1. Plan Availability
   Medica HSA is available statewide and nationwide.

2. How to Access a Provider Directory
   The most up-to-date participating provider information can be accessed on Medica’s website at www.medica.com/uofm. If you need additional information, call Medica Customer Service at 952-992-1814 or 1-877-252-5558 or register at myMedica.com to get personalized information.

3. Changing Clinics
   You can change clinics at any time to a new provider who is a member of the Medica Choice network. You are encouraged to establish a close working relationship with a physician or primary care clinic in order to provide better coordination of your overall health needs.

4. Referrals
   You may see any participating network provider or specialist without a referral. Anytime you receive care from a participating provider, your care is considered “in-network” and eligible services are covered.

5. Out-of-Network Services
   When you receive services outside the Medica service area (Minnesota, North and South Dakota and western Wisconsin) from a non-participating provider, your care is considered “out-of-network” and covered at the coinsurance level after the deductible until the out-of-pocket maximum is met. If you need services outside the Medica service area you may use a national network or providers through the United Healthcare Options PPO network and receive in-network benefits. For a complete listing of providers within these networks, log on to www.medica.com/uofm or call Customer Service.

6. Out-of-Area Coverage
   Emergency medical care and urgent medical care received anywhere in the world is covered. Out-of-network emergency services including emergency ambulance, emergency room visits, emergency hospital admissions, and urgent care will be covered at the in-network benefit levels.
Prime Therapeutics is the Pharmacy Benefits Manager (PBM) for the University of Minnesota UPlan prescription drug benefit program. Fairview Specialty Pharmacy is the exclusive provider of most specialty medications.

A. How the Benefit Works
As a member of a UPlan medical option, you are automatically enrolled in the Prime Therapeutics prescription drug benefit plan. You have a separate ID card for your prescription benefit. Present the card to your local pharmacy when you have your prescription filled so that you will be charged the applicable copay instead of the full cost of the drug.

Copays do not apply to the Medica HSA plan. Instead, prescription drugs are covered in the health savings account, if funds are available. After the deductible is met, prescriptions are covered in the coinsurance level in the medical plan.

B. Drug Formulary
A drug formulary is a continually updated list of prescription medications that represent the current clinical judgment of providers and experts in the diagnosis and treatment of disease. As a reference and informational tool for physicians, pharmacists, and patients, the drug formulary supports the University’s goal of providing UPlan members with safe, effective, high-quality, cost-effective medications to ensure the best medical results. Formularies support other tools that promote quality and optimal results such as drug utilization review and medical treatment guidelines.

The medications listed in the formulary are those that are routinely available as part of your prescription drug benefit plan. Specific drug selection for an individual patient rests solely with the physician.

The drug products in the UPlan formulary are organized by sections based on their therapeutic category. Drugs are listed by generic name and by brand name, if they have one. Brand names are included as a reference to assist in product recognition. Generally all applicable dosage forms and strengths of the drug cited are included in the formulary, although there are exceptions to this.

Over-the-Counter (OTC) Products
Certain over-the-counter (OTC) products are covered in the pharmacy benefit with a prescription. Examples of commonly used OTC products that are covered include insulin, diabetes monitoring products, allergy medications, gastrointestinal medications, and other OTC products specifically listed in the formulary.

Using the Formulary
If you know the name of the drug your doctor has prescribed, or a drug that you think you may need, look first in the index at the end of the formulary. If you look for a particular drug and cannot find it within the formulary, you should consider the following reasons:

» The drug may be a Non-Formulary drug and available to participants at a $75 copay.
» The drug may be a Compound Prescription.
» The drug may be covered as a Medical benefit and may be provided directly by your physician under the Medical portion of the UPlan Medical and Pharmacy Program.
» The drug may be excluded from UPlan coverage (see V. Benefit Features, Q. Prescription Drugs).

C. Tiered Copay Format
Drugs represented in the UPlan Formulary have varying costs to the member. Generic drugs typically are available at the lowest cost; brand-name drugs on the UPlan Formulary will generally cost more than generics; and brand-name drugs not on the list will generally cost the most. Generics should be considered the first line of prescribing.

A tiered format places drugs into tiers or levels of cost sharing by the member. Generic Plus drugs in Tier 1 include all generic drugs and selected brand-name drugs. In the formulary, Generic Plus products are marked as Drug Tier 1, and the copay is $10 for a 30-day supply.
IV. Pharmacy Benefits

Formulary Brand-Name drugs in Tier 2 have an intermediate member copayment. In the formulary, Brand-name products are marked as Drug Tier 2, and the copay is $30 for a 30-day supply.

Non-Formulary drugs in Tier 3 have the highest member copayment. This tier includes all covered brand-name products that were not selected for Tier 2. In most cases, there will be reasonable alternatives in Tier 1 or Tier 2 for products found in this highest tier. Non-formulary drugs are not listed in the formulary. The member copay for Non-formulary products is $75 for a 30-day supply.

D. Preventive Medications under the Affordable Care Act (ACA)

The Affordable Care Act brings improvements in the Pharmacy Program. The copayment is reduced to $0 for select preventive medications specified in the Affordable Care Act and contraceptives in the Generic Plus Category. Medica HSA covers these medications at 100%.

Select preventive medications covered without a copay include:

» All contraceptives at the Generic Plus level on the Pharmacy program, and any contraceptives on the Medical program. (Formulary and Non-Formulary Brand contraceptives stay covered at one copay for a 90-day supply.)

» Breast cancer preventive prescriptions, fluoride supplements, and tobacco cessation medications that are considered prescription medications.

» Over-the-counter (OTC) preventive medications with a prescription, including 81 mg aspirins, folic acid supplements, tobacco cessation medications, iron, and vitamin D supplements. (Note: To have these covered without a cost on the Pharmacy Program, you need to present a prescription at your pharmacy.)

E. Generic Drug Products: Generic Substitution

Generic substitution is the action by a pharmacist to select the source (manufacturer) of a drug product from among those drug products (brand and generic) that are considered to be therapeutically equivalent. Unless expressly indicated by the prescriber as “dispense as written” or D.A.W., pharmacists in Minnesota may dispense generic drug products that, in their professional judgment, are therapeutically equivalent unless the patient requests otherwise. In instances where the prescriber indicates D.A.W. or the patient requests D.A.W., the cost difference between the brand and the generic will be applied to the Generic Plus copay. The cost difference does not apply toward the annual out-of-pocket maximum.

Generic drug approvals by the U.S. Food and Drug Administration (FDA) since 1984, and most generic approvals prior to 1984, have been based upon a demonstration that the generic drug product is therapeutically equivalent to the brand name product.

To gain FDA approval as a therapeutically equivalent product:

1. The generic drug must contain the same active ingredient(s), be the same strength, and the same dosage form as the reference (brand name) product, and

2. The manufacturer of the generic drug must demonstrate to the FDA that it has the same rate and extent of absorption as the brand-name product.

When a generic drug product has met the FDA requirements for therapeutic equivalence, the generic drug product can be substituted with the full expectation that the substituted product will produce the same clinical effect and safety profile as the prescribed product.

F. Specialty Pharmacy

Most specialty drugs will be provided exclusively through Fairview Specialty Pharmacy and Fairview clinic and hospital pharmacies. In Duluth, specialty drugs will also be available at Essentia Health and Northland.
Specialty drugs are generally prescribed for people with complex or ongoing medical conditions such as multiple sclerosis, hemophilia, hepatitis C, rheumatoid arthritis and other complex conditions. Specialty drugs are high cost and have one or more of the following characteristics:

- They are often injected or infused, but some may be taken by mouth.
- They have unique storage or shipment requirements.
- Members using specialty medications need additional education and support from a health care professional due to the complexity of use and the potential for some serious side effects.
- They are not stocked at all retail pharmacies.

You can also get more information about specialty medications at [www.fairviewspecialtyrx.org/uplan](http://www.fairviewspecialtyrx.org/uplan).

**G. Mail Service Delivery**

Mail Service Delivery offers you the opportunity to submit prescriptions by mail or have prescribers fax in prescriptions. The prescription is then processed and delivered directly to you. Members can receive a 90-day supply for two copays through Mail Service Delivery. Mail order forms and contact information can be found at [www.myprime.com](http://www.myprime.com).

**H. Medication Therapy Management**

Medication Therapy Management (MTM) allows UPlan members to be more involved in their medication therapy decisions, which could result in improved health outcomes plus savings on medication copays.

The MTM program is offered to UPlan members including active employees, early retirees, disabled participants, and their dependents. You are eligible for the MTM program if you take four or more UPlan-covered prescription and covered over-the-counter medications for chronic conditions, you are referred by your physician to the program, or you have diabetes. MTM begins with a face-to-face meeting between you and a specially trained pharmacist. The pharmacist will complete a comprehensive health assessment and will review all of your prescription, over-the-counter, and herbal medications to be sure they are appropriate, effective, safe, and convenient. The UPlan pays the full cost of MTM services so there is no copay or other cost to you for the consultations with the pharmacist.

Your MTM pharmacist will educate you on your medications, answer your questions, and develop a medication therapy treatment plan that you can share with your primary care provider. By doing this review the pharmacist can identify, resolve, and prevent medication-related problems.

The pharmacists in the UPlan MTM program have received education on the delivery of MTM during their degree program, or they completed an additional, approved, continuing education course on providing MTM services.

MTM is a specialized service with a limited network of MTM pharmacists located in clinics and community pharmacies. If the MTM pharmacist you choose is in a clinic, he or she does not need to be in your own medical plan and clinic. If your MTM pharmacist choice is in a pharmacy, he or she does not need to be in the pharmacy where you fill prescriptions.

MTM pharmacists serve all five campuses. The directory of MTM pharmacists is online at [humanresources.umn.edu/pharmacy-program/medication-therapy-management](http://humanresources.umn.edu/pharmacy-program/medication-therapy-management).

**I. Prior Authorization (PA)**

Prior Authorization may be required in the UPlan Pharmacy Program.

Certain drugs require prior authorization to encourage safe and clinically appropriate use (drugs indicated with PA in the formulary and any compound medications). It will be necessary for your prescriber or Medication Therapy Management (MTM) pharmacist to complete and submit a PA form to Prime Therapeutics to request continued coverage of the selected drug. If the prior authorization is approved by Prime Therapeutics, you can continue to take your drug at the $10 Generic Plus copay. If the prior authorization is not approved by Prime Therapeutics, you can continue to take your drug at the regular tier copay.
IV. Pharmacy Benefits

If either you or your prescriber decides not to apply for the prior authorization, you can continue to take your drug, but you will be charged the full price of the drug.

Occasionally a UPlan Medical and Pharmacy Program member, for reason of medical necessity, may need to take a drug that is ordinarily subject to a higher copay under the benefit structure. When this occurs, the copay for that member may be reduced to the lowest level copay available under the drug benefit. Such an exception is achieved through an appeal process whereby the member’s prescriber provides adequate evidence to Prime Therapeutics that the requested drug is medically necessary. Upon approval by Prime Therapeutics, the $30 Brand Formulary copay, or the $75 Non-Formulary copay, will be reduced to the Generic Plus copay of $10 for that drug.

You can find out if your drug has Prior Authorization, designated by PA after the drug name, by looking in the formulary. You can also get more information about your Prior Authorization program at www.myprime.com.

J. Step Therapy
A process called Step Therapy is used in certain therapeutic drug categories to encourage use of safe, clinically appropriate or more cost-effective drugs. With Step Therapy, your prescriber is encouraged to prescribe a more cost-effective Step 1 drug before trying a less cost-effective Step 2 drug. Most drugs at Step 1 are available at the $10 Generic Plus copayment.

If you have already taken the Step 1 drug, or if there is some medical reason why you cannot do so, your prescriber can submit a prior authorization request to Prime Therapeutics on your behalf. The prior authorization form is available on the website. Approved Step 2 drugs are also available at the $10 Generic Plus copayment. If the prior authorization request is not approved by the pharmacy staff at Prime Therapeutics, you will pay the $30 Brand Formulary copayment for the Step 2 formulary drug.

K. Split Fill Program
The Split Fill program is designed to maximize use of certain high cost drugs while managing the cost effectiveness of the drug therapy. For example, oncology drugs are frequently poorly tolerated. As a result, a large amount of the prescribed drug is wasted because the whole prescription is not used.

The Split Fill program is designed to help you better manage use of the drug and, where needed, adjust the prescription. Prime Therapeutics Specialty Pharmacy in conjunction with Fairview’s Specialty Therapy Management team will administer the program.

When you receive a prescription and have it filled at the Fairview Specialty Pharmacy:

1. Half of the prescription will be dispensed to you. Your copay is $0 for each fill for up to six fills.

2. You will receive a call from a Fairview Specialty Therapy Management nurse between 7 and 10 days after the first fill. The nurse will assess continuation of the therapy and any drug-related effects. The decision to fill the remaining part of the prescription is based upon review by your physician and Fairview Specialty Pharmacy.

3. After six fills and if you are continuing therapy, a Prior Authorization will be put in place. You will then be able to fill a 30-day supply at the normal copay.
L. Pharmacy and Therapeutics (P&T) Committee
The University’s UPlan Pharmacy Program Clinical Review Committee, consisting of University employees with clinical, drug therapy, and policy expertise, selects drugs for this formulary based on recommendations of an independent Prime Therapeutics’ Pharmacy & Therapeutics (P&T) Committee that includes practicing physicians and pharmacists. Decisions on which drugs to include in the formulary are based on safety, efficacy, uniqueness, and cost. When a new drug is considered for formulary inclusion, it will be reviewed and compared to similar drugs currently included in the University of Minnesota Formulary.

When new drug products are added to the formulary
New drugs that are generically will be added as soon as possible at the Generic Plus level. New brand drugs will be Non-Formulary until they are reviewed by the Prime Therapeutics P&T Committee and the UPlan Pharmacy Program Clinical Review Committee. Formulary decisions are communicated quarterly on the website at www.myprime.com.

M. Covered Drug Products Policy
Pharmaceutical care is a vital component of the overall health care benefit provided for UPlan members. It is essential that the UPlan Pharmacy Program be effectively managed, and that medications are selected for coverage under the program using a logical process that assures the inclusion of safe, effective, and cost appropriate medications for the program. The following policy details the process by which the Pharmacy Program will determine which medications will be covered by the Plan.

Designation of a drug product as covered means that the Plan pays for part, or all, of the drug product cost as a part of the UPlan Pharmacy Program. Any drug product designated as covered may be obtained by an enrolled member, but the drug coverage, access, and cost may be subject to certain cost-sharing, drug utilization, and management tools.

Drug products, except as otherwise limited in this Summary of Benefits, will be designated as covered when one or more of the following situations exist:

1. Prescription drug products approved by the U.S. Food & Drug Administration (FDA) for marketing in the United States when used according to FDA approved labeling, except for those that have been designated to be subject to certain limitations in coverage or designated as not covered.

2. Prescription drug products approved by the U.S. Food & Drug Administration (FDA) for marketing in the United States when used beyond FDA approved labeling in those situations where the use is supported by well-documented, evidence-based research. Coverage for use beyond the FDA approved labeling may require step therapy, prior authorization, or other review procedures by the Pharmacy Benefit Manager to document appropriate use.

3. Selected over-the-counter (OTC) drug products when listed in the drug formulary and prescribed by the patient’s provider.

N. Non-covered Drug Products
Designation of a drug product as not covered means that the UPlan does not pay for any part of the cost or administration of the drug product. Any drug product designated as not covered may be obtained by a member; however, the member must pay the full cost charged for that drug product. When a drug product is not covered, then the cost of administering the drug is not covered, unless specifically covered under the medical benefits of the Plan.

Drug products will be designated as not covered when one of more of the following situations exist:

1. Prescription and other drug products not approved by the FDA for marketing in the United States.

2. The set of prescription drugs classified as less than effective by the FDA’s Drug Efficacy Study Implementation (DESI) review.

3. Biotechnological drug therapy that has not received FDA approval for the specific use being requested, except for off-label use in cancer treatment as specified by law.

4. Prescription drug products when the drug product is not used according to FDA-approved labeling, unless such use is supported by well-documented, evidence-based research.
IV. Pharmacy Benefits

5. Prescription drug products that are used for cosmetic purposes as designated by the Plan.

6. Over-the-counter (OTC) or non-prescription drug products such as herbal, nutritional, and dietary supplements, except for insulin and other OTCs specifically listed in the formulary.

7. Prescription drug products or drug products that are otherwise covered, which require prior authorization (PA) when a PA has not been submitted by the member’s provider.

8. Prescription drug products or drug products that are otherwise covered, which require step therapy when the preceding steps (or drug products) have not been prescribed for and used by the member or when a PA has not been submitted by the member’s provider.

Drug products may be designated as not covered when they have been determined to have substantially the same, or even less, safety and effectiveness when compared to other drug products in the same therapeutic category, especially when the not covered drug product has a cost that is substantially higher than the cost of similar or better therapeutic alternatives.

Drug products may be designated as not covered when one or more of the following situations exist:

1. Single source brand drug products in a therapeutic category that has other drug entities in the same therapeutic category with similar or better safety and effectiveness and that have FDA-approved therapeutically equivalent generics at a substantially lower cost

2. Drug products in which the molecular configuration is altered but works in a similar clinical manner when the change results in patent status and close molecular alternatives that do not have a substantial therapeutic advantage in safety or effectiveness

3. Drug products where the only difference is the dosage forms (e.g., tablet vs. capsule, or sustained release vs. regular drug product)

4. Combination drug products especially, but not exclusively, when the combination results in brand-name status for the combination drug product when each of the drug entities would otherwise be available as a generic or at substantially lower prices

5. Drug products that are found to be substantially less safe than alternative drug products without a substantial and counterbalancing improvement in effectiveness

Occasionally a UPan Medical and Pharmacy Program member, for reason of medical necessity, may need to take a drug that is not covered under the UPan Pharmacy Program. If a drug is not covered, the member can still access the medication, but he/she would need to pay the full cost. When this occurs, the member’s prescriber has the option to submit a formulary exception request to Prime Therapeutics. If the formulary exception request is approved by Prime Therapeutics, the member will be able to receive the medication for either $30 or $75. If the formulary exception request is not approved, the member can continue to access the medication, but he/she will need to pay the full cost of the drug.

O. Additional Coverage Status Information

Covered drug products may be subject to various limitations including cost sharing (e.g., deductibles, copayments, and coinsurance), utilization management tools (e.g., prior authorization, step therapy, or generic substitution), fraud and abuse review, and other benefit design tools (e.g., utilization review, refill, quantity, dose, and duration limits).

The coverage status of a drug product may change (e.g., covered to not covered or vice versa) from time to time depending upon availability of new evidence and research.

Certain prescription or other drug products may be excluded from coverage (i.e., not paid for by the Plan); however, such exclusion from coverage does not prevent or limit members’ rights to purchase entirely with their own resources any legally available drug product.
Here are some of the key terms that will help you understand the following benefits charts for each plan.

**Copay**
A copay is a set amount that you either pay up front or are billed by your physician for non-preventive medical services and most prescriptions. For example, the Base Plan copay for a primary care physician visit is $25 and the copay for a generic drug prescription is $10. If during your office visit, your doctor has another doctor examine you, there may be a second copay for that service. If the doctor is a specialist, you pay the specialist copay.

**Primary and Specialty care copays**
You pay the primary care copay for visits to family medicine, internal medicine, obstetrics/gynecology, and pediatric physicians. The primary care copay also applies to chiropractic, acupuncture, physical, occupational, and speech therapy, and mental health/substance abuse services. Specialty care copays apply to all other providers.

**Deductible (In-Network)**
A deductible is the set amount you pay each year for non-preventive services where a copay doesn’t apply. For the UPlan, the deductible applies primarily to lab services, x-rays, and in- and out-patient hospital visits. Lab work included in a preventive visit may trigger the deductible, depending on the physician billing practices. For the base plan, the maximum annual amount is $100 per person and $200 per family. Once it is paid, medical services for which a deductible applies are paid at 100% for the remainder of the year. Services paid at 100% could, for example, range from a $150 lab charge to a $15,000 hospital bill.

**Coinsurance**
Coinsurance is the percentage of the allowed amount you must pay for certain covered services. Coinsurance applies after deductibles and copayments. For example, the plans pay out-of-network care at 70% after the deductible is met so you would pay 30% coinsurance. The coinsurance no longer applies once you have reached the out-of-pocket maximum.

**Preventive Care**
Preventive services can help keep you from having health problems or catch a potential problem early. Preventive care includes such services as routine physical exams, routine screenings, and immunizations. Preventive cancer screenings are routine, scheduled screenings recommended for all members of a specific population including screening for breast cancer, cervical cancer, ovarian cancer, colon cancer, and prostate cancer.

**Preventive and non-preventive care received during a single visit**
If you receive both types of care during a single visit, the preventive care portion of your visit will be covered at 100%. You will likely pay a copay or coinsurance for any additional services that are not considered preventive. If your plan includes a deductible, you will pay the cost for the non-preventive services until the deductible is met.

**What preventive care does not cover**
A service is not considered preventive if the doctor diagnoses, monitors, or treats a problem or symptom you already have. Examples include: earwax removal; treatment of earache or sore throat; X-rays to diagnose a cough or broken bones; specific health care concerns such as ongoing headaches, high cholesterol, or high blood pressure.

**Out-of-Pocket Maximum**
An out-of-pocket maximum is the most each person must pay each year toward the allowed amount for covered services. After a person reaches the out-of-pocket maximum, the Plan pays 100% of the allowed amount for covered services for that person for the rest of the year.

**Out-of-Network Care**
Out-of-network care is defined as care received from a nonparticipating provider. All of the medical plan options include out-of-network coverage for eligible medical services provided by a licensed health care provider who does not participate in the plans’ networks. Coverage will be at a 70% coinsurance level after a deductible is satisfied.
V. Benefit Features Chart

A. Lifetime Maximum

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/Essential</th>
<th>Medica ACO Plan</th>
<th>Medica Choice Regional</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

B. Deductible

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/Essential</th>
<th>Medica ACO Plan</th>
<th>Medica Choice Regional</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network: employee only</td>
<td>$100</td>
<td>$100</td>
<td>$200</td>
<td>Total in-network and out-of-network: $1,500 per employee</td>
<td></td>
</tr>
<tr>
<td>In network: family</td>
<td>$200</td>
<td>$200</td>
<td>$400</td>
<td>Total in-network and out-of-network: $3,000 family total (No embedded individual total)</td>
<td></td>
</tr>
<tr>
<td>Out-of-network: employee only</td>
<td>$600</td>
<td>$600</td>
<td>$600</td>
<td>Total in-network and out-of-network: $1,500 per employee</td>
<td></td>
</tr>
<tr>
<td>Out-of-network: family</td>
<td>$1,200</td>
<td>$1,200</td>
<td>$1,200</td>
<td>Total in-network and out-of-network: $3,000 family total (No embedded individual total)</td>
<td></td>
</tr>
</tbody>
</table>

**Medica Health Savings Account (HSA)**

The account can be used to offset the annual deductible. For midyear enrollees the accounts will be prorated per pay period.

The deductibles are not reduced.

The University allocates

» Per employee
  $750

» Per family
  $1,500
C. Out-of-Pocket Maximums

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>For All Other Services (those not covered by a separate Out-of-Pocket Maximum)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Combined In-Network and Out-of-Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per person per plan year</td>
<td>$2,500</td>
<td>$2,500</td>
<td>$2,500</td>
<td>Employee only: $3,000</td>
</tr>
<tr>
<td>Per family per plan year</td>
<td>$4,000</td>
<td>$4,000</td>
<td>$4,000</td>
<td>Family total: $6,000</td>
</tr>
<tr>
<td>For Prescription Drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per person per plan year</td>
<td>$750</td>
<td>$750</td>
<td>$750</td>
<td>No separate maximum</td>
</tr>
<tr>
<td>Per family per plan year</td>
<td>$1,500</td>
<td>$1,500</td>
<td>$1,500</td>
<td>Eligible prescriptions count toward the Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

Notes:

> The in-network deductible applies to expenses without a copay, primarily in- and out-patient hospital and lab/x-ray.
> The pharmacy out-of-pocket maximum does not apply toward the medical plan out-of-pocket maximum, except for Medica HSA.
> Out-of-network prescription expenses do not apply against any out-of-pocket maximum.
> Prescription drug expenses used during inpatient admission do not count toward the prescription drugs out-of-pocket maximum.
> Prescription drug expenses for the treatment of infertility do not count toward any out-of-pocket maximum.
> Prescription drug expenses for growth hormones do not count toward any out-of-pocket maximum.
> Price difference between brand name and generic drugs is your responsibility and is not applied toward the Out-of-Pocket Maximums for Prescription Drugs or All Other Services.
> For Medica HSA, eligible pharmacy costs are combined with all other eligible expenses and applied toward satisfying your annual plan deductible and out-of-pocket maximum. There is no separate Out-of-Pocket Maximum for Prescription Drugs.
> The amounts you pay for infertility expenses (coinsurance amounts in excess of the $5,000 annual maximum on medical expenses) do not count toward any out-of-pocket maximum.
> The coinsurance for diabetic insulin pumps and related supplies is your responsibility and is not applied toward the Out-of-Pocket Maximum for Prescription Drugs, but does apply to the Out-of-Pocket Maximum for All Other Services.
## V. Benefit Features Chart

### D. Ambulance

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ground and air ambulance to the nearest facility</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Ambulance transfers between hospitals</td>
<td>100% after deductible</td>
<td>100% after deductible</td>
<td>100% after deductible</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Medical evacuations or transfers pre-authorized by UnitedHealthcare Global</td>
<td>100% after deductible</td>
<td>100% after deductible</td>
<td>100% after deductible</td>
<td>90% after deductible</td>
</tr>
</tbody>
</table>

**Out-of-network**

For out-of-network coverage, refer to **N. Out-of-Network Care**

### Notes:

- Coverage is limited to: transportation by a licensed ambulance during a medical emergency; and pre-arranged transfers requested by a physician.
- Political and natural disaster evacuations through UnitedHealthcare Global are not covered under the UPlan Medical Program and are not part of the cost of the UPlan Medical Program.
- For in-and-out-of-network:
  - **Emergency**: Emergency ambulance transportation (ground and air) by a licensed ambulance service to the nearest hospital where emergency health services can be performed.
  - **Non-Emergency**: Transportation by professional ambulance to and from a medical facility. Transportation by regularly scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment.
- Not Covered:
  - Please refer to the **VII. Exclusions**.
E. Chiropractic Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic services for rehabilitative care provided to diagnose and treat acute neuromuscular-skeletal conditions</td>
<td>100% after $25 copay per office visit</td>
<td>100% after $20 copay per office visit</td>
<td>100% after $40 copay per office visit</td>
<td>90% after deductible</td>
</tr>
<tr>
<td><strong>Out-of-network</strong></td>
<td></td>
<td></td>
<td></td>
<td>For out-of-network coverage, refer to N. Out-of-Network Care</td>
</tr>
</tbody>
</table>

Notes:
» In-network benefits are available when members receive services from providers in their plan’s chiropractic care network.

Not Covered:
» Please refer to the VII. Exclusions.
### V. Benefit Features Chart

#### F. Dental Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room dental care</td>
<td>In-network and Out-of-network: 100% after $100 copay per visit, waived if admitted.</td>
<td>In-network and Out-of-network: 100% after $100 copay per visit, waived if admitted.</td>
<td>In-network and Out-of-network: 100% after $100 copay per visit, waived if admitted.</td>
<td>In-network and Out-of-network: 90% after deductible</td>
</tr>
<tr>
<td>Medically Necessary services to treat and restore damage done to sound, natural teeth as a result of an accidental injury that occurs while you are a Plan Member. Coverage is for damage caused by external trauma to face and mouth only, not for cracked or broken teeth that result from biting or chewing. Treatment and repair must be initiated within twenty-four (24) months of the date of injury.</td>
<td>100% after $25 Primary/ $35 Specialty copay</td>
<td>100% after $20 Primary/ $30 Specialty copay</td>
<td>100% after $40 Primary/ $50 Specialty copay</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>The Plans cover the services listed below at:</td>
<td>Inpatient and Outpatient: 100% after deductible</td>
<td>Inpatient and Outpatient: 100% after deductible</td>
<td>Inpatient and Outpatient: 100% after deductible</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Medically Necessary surgical or nonsurgical treatment of temporomandibular joint disorder (TMD) and craniomandibular disorders (CMD)</td>
<td>Inpatient and Outpatient: 100% after deductible</td>
<td>Inpatient and Outpatient: 100% after deductible</td>
<td>Inpatient and Outpatient: 100% after deductible</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>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 jaw, cysts, and lesions.</td>
<td>100% after deductible</td>
<td>100% after deductible</td>
<td>100% after deductible</td>
<td>90% after deductible</td>
</tr>
</tbody>
</table>
F. Dental Care (Continued)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Plans cover the services listed below at:</td>
<td>Inpatient and Outpatient: 100% after deductible</td>
<td>Inpatient and Outpatient: 100% after deductible</td>
<td>Inpatient and Outpatient: 100% after deductible</td>
<td>Inpatient and Outpatient: 90% after deductible</td>
</tr>
<tr>
<td>Cleft lip and cleft palate for a dependent child under age 18, including orthodontic treatment, dental implants, and oral surgery directly related to the cleft</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesia, inpatient, and outpatient hospital charges for dental care provided to a covered person who meets one (1) of the following conditions:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» is a child under age five (5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» is severely disabled; or</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» has a medical condition that requires hospitalization or general anesthesia for dental treatment. Coverage is limited to facility and anesthesia charges.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthognathic surgery for the treatment of skeletal malocclusions where a functional occlusion cannot be achieved through nonsurgical treatment alone and where a demonstrable functional impairment exists. Functional impairments include, but not limited to, difficulties in chewing, breathing, or swallowing. Associated dental and orthodontic services (pre- or post-operatively) are not covered as part of this benefit.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For out-of-network coverage, refer to N. Out-of-Network Care

Not covered:

» Charges for any appliance or service for or related to dental implants, including hospital charges.

» Charges for dental or oral care except for those specified in the Benefits Features chart above

» Please refer to the VII. Exclusions.

Notes:

• For cleft lip and cleft palate, if a dependent child is also covered under a dental plan which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same copayment, conditions, and limitations as durable medical equipment.

• Treatment must occur while you are covered under this Plan.
## V. Benefit Features Chart

### G. Durable Medical Equipment and Supplies

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Plans cover the services listed below at:</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME), which includes such items as:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>wheelchairs, hospital beds, ventilators, oxygen equipment, and siderails</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical supplies, which includes splints, nebulizers, surgical stockings, casts, dressing, and catheter kits.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wigs coverage for hair loss caused by alopecia areata is limited to one annually</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered prosthetics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial lens(es) after surgery for: - aphakia - keratoconus</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial lens(es) implanted during cataract surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing aids, batteries, and accessories are eligible when prescribed by a participating audiologist or otolaryngologist.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cochlear implants and bone-anchored hearing aids (BAHA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enteral feedings, when the sole source of nutrition used to treat a life-threatening condition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special dietary treatment for phenylketonuria (PKU) when prescribed/recommended by a physician</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
G. Durable Medical Equipment and Supplies (Continued)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Custom foot orthotics and custom orthopedic shoes that are part of a brace or custom molded insert that are Medically Necessary</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>90%</td>
</tr>
<tr>
<td>Diabetic supplies (Insulin pumps and related supplies, and continuous glucose monitor sensors)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ostomy supplies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phototherapy devices and/or bulbs for treatment of seasonal affective disorder (SAD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-network</strong></td>
<td>For out-of-network coverage, refer to N. Out-of-Network Care</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

» Durable Medical Equipment (DME) includes equipment purchased through a DME vendor or equipment obtained in an inpatient setting for use in your home or dwelling.

» Durable Medical Equipment is covered up to the allowed amount to rent or buy the item. Allowable rental charges are limited to the allowed amount to buy the item. The Plan Administrator has the right to determine whether an item will be approved for rental versus purchase.

» Coverage for durable medical equipment will not be excluded solely because it is used outside the home.

» No more than a 90-day supply of diabetic supplies (Insulin pumps and related supplies, and continuous glucose monitor sensors) will be covered and dispensed at one time.

» Diabetic supplies other than Insulin pumps and related supplies, and continuous glucose monitor sensors, will be covered under Prime Therapeutics.

» No more than a 90-day supply of ostomy supplies will be covered and dispensed at one time.

» Payment will not exceed the cost of an alternate piece of equipment or service that is effective and Medically Necessary.

» For adults, hearing aids and hearing aid evaluation tests that are to determine the appropriate type of aid (limited to one aid per ear), are covered up to a benefit limitation of once every three (3) years.

» For dependent children under age 19, hearing aids and hearing aid evaluation tests that are to determine the appropriate type of aid (limited to one aid per ear) are covered as Medically Necessary.

**Not Covered:**

» Personal and convenience items or items provided at levels that exceed the Claims Administrator’s determination of Medically Necessary

» Implantable hearing aids [other than cochlear implants and bone-anchored hearing aids (BAHA)]

» Replacement or repair of covered items, if the items are 1) damaged or destroyed by misuse, abuse or carelessness; 2) lost; or 3) stolen

» Labor and related charges for repair estimates of any covered items that are more than the cost of replacement by an approved vendor

» Sales tax, mailing, delivery charges, or service call charges
G. Durable Medical Equipment and Supplies (Continued)

» Items that are primarily educational in nature or for vocation, comfort, convenience, or recreation
» Modification to the structure of the home including, but not limited to, its wiring, plumbing, or charges for installation of equipment
» Vehicle, car, or van modifications, including but not limited to, hand brakes, hydraulic lifts, and car carriers
» Charges for services or supplies that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, exercise equipment, air purifiers, air conditioners, dehumidifiers, heat appliances, water purifiers, hypoallergenic mattresses, waterbeds, vehicle lifts, computers and related equipment, communication devices, and home blood pressure kits

» Charges for lenses, frames, contact lenses, or other optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors
» Duplicate equipment, prosthetics, or supplies
» Nonprescription and over-the-counter charges for arch supports, foot orthotics and orthopedic shoes, including biomechanical evaluation and negative mold foot impressions, except as specified above
» Enteral feedings and other nutritional and electrolyte substances, except for conditions that meet Medically Necessary criteria as determined by the Claims Administrator
» Oral dietary supplements, except for phenylketonuria (PKU)
» Other equipment and supplies the Claims Administrator determines not eligible for coverage
» Please refer to the VII. Exclusions.
H. Emergency Care

| Benefit                                                                 | Medica Elect/Essential  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network and Out-of-network services received during an emergency room</td>
<td>Medica Choice Regional</td>
</tr>
<tr>
<td></td>
<td>Medica ACO Plan</td>
</tr>
<tr>
<td></td>
<td>Medica Choice National</td>
</tr>
<tr>
<td></td>
<td>Medica HSA</td>
</tr>
<tr>
<td>In-network and Out-of-network services received during an emergency room</td>
<td>100% after $100 copay per incident; copay waived if admitted within 24 hours</td>
</tr>
<tr>
<td>MRI and CT Scans</td>
<td>$50 office visit copay</td>
</tr>
<tr>
<td>All other lab and diagnostic imaging</td>
<td>100% coverage after deductible</td>
</tr>
</tbody>
</table>

H. Urgent Care

| Benefit                                                                 | Medica Elect/Essential  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network and Out-of-network services received during an urgent care visit</td>
<td>Medica Choice Regional</td>
</tr>
<tr>
<td></td>
<td>Medica ACO Plan</td>
</tr>
<tr>
<td></td>
<td>Medica Choice National</td>
</tr>
<tr>
<td></td>
<td>Medica HSA</td>
</tr>
<tr>
<td>In-network and Out-of-network services received during an urgent care visit</td>
<td>100% after $25 copay per incident</td>
</tr>
<tr>
<td>MRI and CT Scans</td>
<td>$50 office visit copay</td>
</tr>
<tr>
<td>All other lab and diagnostic imaging</td>
<td>100% coverage after deductible</td>
</tr>
</tbody>
</table>

Notes:

» Emergency Medical Care and Notification of Emergency Admission: When it appears that a condition caused by an illness or accident requires treatment without delay to prevent serious harm, call 911 or go to the nearest Hospital Emergency Department. You do not need to notify your Claims Administrator of a visit to an Emergency Room.

» If your Emergency Room physician admits you to the hospital, you should notify your Claims Administrator within 48 hours, or as soon as reasonably possible, by calling the Member Services phone number listed on your member card. This notification allows the Administrator to better coordinate your care and to ensure that your claims are handled correctly. Emergency room services are subject to the copayments listed above unless you are admitted within 24 hours for the same condition. Follow-up care for Emergency services (e.g., suture removal, cast changes) is not an Emergency service.

» If the hospital indicates you are in an observation status, rather than being officially admitted to the hospital, the Emergency Room copay will apply. Care provided during the observation period will be included in the Emergency Room copay.

» Urgent Care: Urgent Care problems include injuries or illnesses that require urgent treatment, but are not life-threatening.

» In-Network: Members may seek assistance at any network Urgent Care without contacting the Primary Care Provider.

» Out-of-Network: Seek assistance at the nearest facility. Follow-up care for Urgent Care services (suture removal, cast changes, etc.) is not considered an Urgent Care service.

» See definitions of Emergency Care and Urgent Care in VIII. Definitions.

Not Covered:

» Please refer to the VII. Exclusions.
### V. Benefit Features Chart

#### I. Home Health Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Plans cover the services listed below at:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing services, physical therapy, occupational</td>
<td>100% after $25 copay per home visit</td>
<td>100% after $20</td>
<td>100% after $40 copay</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>therapy, speech therapy, respiratory therapy, child</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>health supervision services, phototherapy services,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>home health aide services, and laboratory services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Parenteral Nutrition - Intravenous Therapy</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>**Other home health services when provided in the Member’s</td>
<td>100% after $25 copay per home visit</td>
<td>100% after $20</td>
<td>100% after $40 copay</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>home. Member is homebound (i.e., unable to leave home</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>without considerable effort due to a medical condition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Lack of transportation does not constitute homebound status.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home-based Intravenous Therapy (homebound status does not apply)</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Out-of-network</strong></td>
<td></td>
<td></td>
<td></td>
<td>For out-of-network coverage, refer to N. Out-of-Network Care</td>
</tr>
</tbody>
</table>

### Notes:

- Home health services are covered only when they are:
  1. Medically Necessary;
  2. provided as rehabilitative or terminal care; and
  3. ordered by a physician, and included in the written home care plan.

- For IV therapy related to prenatal and postnatal maternal and child health services, and preterm high-risk pregnancy services, equipment, supplies, and drugs for these services, as appropriate, are included in the coverage.

- A service shall not be considered skilled nursing service merely because it is performed by, or under the direct supervision of, a licensed nurse. Where such 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 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 that include skilled and non-skilled components) are covered.

- The Plan covers two (2) home health visits within four (4) days of discharge from the hospital if either the mother or the newborn child are confined for a period less than the 48 hours (or 96 hours). See Z. Annual Notifications in this section.

- Ventilator-dependent interpreter services are covered up to 120 hours when provided by a private duty nurse or personal care assistant who has provided home health care services.

### Not Covered:

- Charges for services received from a personal care attendant
- Home health services provided as respite for a primary care giver in the home
- Reimbursement for the above services performed by family members or residents in the Plan Member’s home
- Please refer to the VII. Exclusions.
## J. Hospice Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Plans cover the following services at: Hospice services received through</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>» home care hospice program,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» hospice facility, or</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» hospital-based program that provides supportive and palliative treatment focus for a terminally ill Plan Member with a life expectancy of six (6) months or less</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medically Necessary Inpatient Services required for such things as pain and symptom management</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Respite care (in the home or an inpatient setting) of up to ten (10) days, for the purpose of relieving care-givers as necessary to maintain the Member's comfort in his or her home</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Out-of-network</td>
<td></td>
<td></td>
<td>For out-of-network coverage, refer to N. Out-of-Network Care</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

- Copayments listed under D. Ambulance, G. Durable Medical Equipment and Supplies, K. Inpatient Services, O. Outpatient Services, and Q. Prescription Drugs do not apply.
- A medical review is required to determine which services are eligible for coverage.

**Not Covered:**

- Non-medical services such as legal services, financial counseling, funeral and bereavement services, housekeeping
- Meal services in the Member’s home, or any services provided by the Member’s family or residents in the Member’s home that are not part of the hospice program
- Please refer to the VII. Exclusions.
### V. Benefit Features Chart

#### K. Inpatient Services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Plans cover the services listed below at:</td>
<td>100% coverage after deductible*</td>
<td>100% coverage after deductible*</td>
<td>100% coverage after deductible*</td>
<td>90% after deductible*</td>
</tr>
<tr>
<td>» Room and board and general nursing care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Intensive care and other special care units</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Operating, recovery, and treatment rooms</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Anesthesia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Blood and blood products (unless replaced) and blood derivatives</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Prescription Drugs or other medications and supplies used during a covered hospital admission</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Lab and diagnostic imaging</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Physical, occupational, radiation, and speech therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Physician and other professional medical services provided while in the hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» General nursing care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Bariatric services or surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Out-of-network: For out-of-network coverage, refer to N. Out-of-Network Care

* This is an individual deductible. In the event of a birth, there will be a separate admission deductible for the child(ren).

**Note:**

» Members seeking care for bariatric services or surgery must work with Claims Administrator to coordinate with Center of Excellence facilities.

**Not Covered:**

» Please refer to the VII. Exclusions.
## L. Maternity Services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Plans cover the services listed below at:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Prenatal Services</td>
<td>100% coverage</td>
<td>100% coverage</td>
<td>100% coverage</td>
<td>100% coverage</td>
</tr>
<tr>
<td>» First Postnatal Visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Additional Postnatal Services</strong></td>
<td></td>
<td>100% coverage</td>
<td>100% coverage</td>
<td>90% coverage</td>
</tr>
<tr>
<td>» Home health care services following delivery</td>
<td></td>
<td>100% coverage</td>
<td>100% coverage</td>
<td>90% coverage</td>
</tr>
<tr>
<td><strong>Inpatient hospital stay for labor and delivery services</strong></td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>90% coverage after deductible</td>
</tr>
<tr>
<td>» Labor and delivery services at a free standing birth center</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-network</strong></td>
<td>For out-of-network coverage, refer to N. Out-of-Network Care</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

» Labor, delivery, and postnatal services are not considered preventive under HSA guidelines; therefore, services will be subject to the deductible. However, Medica HSA will cover one postnatal visit at 100%.

» The Plan covers two (2) home health visits within four (4) days of hospital discharge if either the mother or the newborn child is confined for less than the 48 hours (or 96 hours).

**Not Covered:**

» Health care professional services for maternity labor/delivery in the home

» Services from a doula

» Childbirth and other educational classes

» Please refer to the **VII. Exclusions**.

**Newborns’ and Mothers’ Health Protection Act of 1996**

Under Federal law, group health plans such as this Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child.

» May not restrict hospital stay to less than 48 hours following a vaginal delivery

» May not restrict hospital stay to less than 96 hours following a caesarean section

However, Federal law generally does not prohibit the mother’s or newborn child’s attending provider, after consultation with the mother, from discharging the mother or her newborn child earlier than 48 hours or 96 hours, as applicable.
### V. Benefit Features Chart

#### M. Mental Health

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/ Essential Medica Choice Plan</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medically Necessary outpatient professional services for evaluation, crisis intervention, diagnosis, and treatment of mental disorders</td>
<td>100% after $25 copay per visit</td>
<td>100% after $20 copay per visit</td>
<td>100% after $40 copay per visit</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Medically Necessary inpatient and professional services for treatment of mental disorders that require the level of care only provided in a hospital or other licensed residential treatment center</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Emotionally handicapped children at a residential treatment program for emotionally handicapped children as diagnosed under the Minnesota Department of Human Services criteria. Care must be authorized by and arranged through a mental health professional. Treatment must be provided by a hospital or residential treatment center licensed by the appropriate state agency. The child must be a dependent under the age of 18.</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Admission to Intensive Residential Treatment services is dependent upon safety and acuity factors such as the following and is subject to utilization review. Intensive Residential Treatment services include either a residential treatment program serving children and adolescents with severe emotional disturbance, which in Minnesota would be certified under Minnesota Rules parts 2960.0580 to 2960.0700; or a licensed or certified mental health treatment program providing intensive therapeutic services. (for example, in MN, such as an Intensive Residential Treatment Service «IRTS» for adults)</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>90% after deductible</td>
</tr>
</tbody>
</table>

**Out-of-network**

For out-of-network coverage, refer to N. Out-of-Network Care

**Notes:**

- Family therapy is covered if recommended by a Provider treating a dependent child. Please contact your Medical Claims Administrator regarding this benefit.
- All mental health treatment must be provided by a licensed mental health professional operating within the scope of his or her license.
- In-network benefits are available when members receive services from providers in their plan’s mental health network.
- Residential Treatment Services care is provided for acute impairment of behavior or cognition that interferes with activities of daily living to the extent that the welfare of the member or others is endangered; or psychosocial and environmental problems that are likely to threaten the member’s safety or undermine engagement in a less intensive level of care without the intensity of services offered in this level of care.

**Not Covered:**

- Charges for marital, relationship, family, or other counseling or training services, religious counseling, or sex therapy rendered in the absence of a significant mental disorder, except as provided above
- Services for telephone psychotherapy, unless such services are provided as a behavioral health service in accordance with the Medical Claims Administrator’s telemedicine policies and procedures
- Charges for services or confinements ordered by a court or law enforcement officers that the Medical Claims Administrator determines are not Medically Necessary
- Charges for services that are normally provided without charge, including services of the clergy
- Please refer to the VII. Exclusions.
V. Benefit Features Chart

N. Out-of-Network Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only deductible</td>
<td>$600</td>
<td>$600</td>
<td>$600</td>
<td>$1,500</td>
</tr>
<tr>
<td>Family deductible per person:</td>
<td>$600</td>
<td>$600</td>
<td>$600</td>
<td>N/A</td>
</tr>
<tr>
<td>Family deductible maximum</td>
<td>$1,200</td>
<td>$1,200</td>
<td>$1,200</td>
<td>$3,000</td>
</tr>
<tr>
<td>Coinsurance after deductible is met</td>
<td>70% up to annual out-of-pocket maximum, then 100% coverage</td>
<td>70% up to annual out-of-pocket maximum, then 100% coverage</td>
<td>70% up to annual out-of-pocket maximum, then 100% coverage</td>
<td>70% up to annual out-of-pocket maximum, then 100% coverage</td>
</tr>
</tbody>
</table>

Notes:

» For eligible medical services received from a licensed health care provider who is not in your plan’s provider network

» Does not apply to prescription drugs obtained outside the pharmacy network

» Refer to H. Emergency Care and Urgent Care coverage for services received out of network.

» For out-of-network services, in all cases the amounts above the U&C charges are your responsibility and do not count toward the Deductible or the Out-of-Pocket Maximum.

» All members seeking services from out-of-network providers may be subject to balance billing from the provider. Balance billing means you are responsible for the difference between the treating physician’s submitted charges and the allowed amount, in addition to the out-of-network deductible/coinsurance.
### V. Benefit Features Chart

#### O. Outpatient Services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery and anesthesia (including all services related to the surgery and delivered at the time of surgery)</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>MRI and CT Scans</td>
<td>$50 office visit copay</td>
<td>$40 office visit copay</td>
<td>$50 office visit copay</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>All other lab and diagnostic imaging</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>90% after deductible</td>
</tr>
<tr>
<td><strong>The Plans cover the services listed below at:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Radiation and chemotherapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Kidney dialysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Pain management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Cardiac rehabilitation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Diabetes self-management training</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Other non-surgical outpatient services not otherwise described above</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical, occupational, and speech therapy</td>
<td>100% after $25 copay per visit</td>
<td>100% after $20 copay per visit</td>
<td>100% after $40 copay per visit</td>
<td>90% after deductible</td>
</tr>
</tbody>
</table>

**Out-of-network**: For out-of-network coverage, refer to N. Out-of-Network Care

### Notes:
The Plan covers genetic testing when test results will directly affect treatment decisions or frequency of screening for a disease or when results of the test will affect reproductive choices.

### Not Covered:
Please refer to the VII. Exclusions.
## V. Benefit Features Chart

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits for illness</td>
<td>$25 Primary/ $35 Specialty copay</td>
<td>$20 Primary/ $30 Specialty copay</td>
<td>$40 Primary/ $50 Specialty copay</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Surgical Services performed during an office visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services to diagnose an infertility condition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes self-management training</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing aid exams, audiometric tests, and audiologist evaluations that are provided by an Audiologist or Otolaryngologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convenience clinic/Retail health clinic Virtual care (telephonic or online)</td>
<td>$15 copay</td>
<td>$15 copay</td>
<td>$20 copay</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>MRI and CT Scans</td>
<td>$50 office visit copay</td>
<td>$40 office visit copay</td>
<td>$50 office visit copay</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>All other lab and diagnostic imaging</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Allergy testing and injections</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Infertility treatment</td>
<td>80% to an annual maximum of $5,000</td>
<td>80% to an annual maximum of $5,000</td>
<td>80% to an annual maximum of $5,000</td>
<td>80% to an annual maximum of $5,000 after deductible</td>
</tr>
</tbody>
</table>

### Out-of-network

For out-of-network coverage, refer to N. Out-of-Network Care

### Notes:

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

» Infertility treatment and assisted reproductive technology services including IVF, GIFT, and ZIFT for covered persons diagnosed with infertility are covered at 80% coinsurance and limited to an annual maximum of $5,000. The amounts you pay for infertility expenses (coinsurance amounts in excess of the $5,000 annual maximum) do not count toward any out-of-pocket maximum. Prescription drugs used for the treatment of infertility are covered under the Prescription Drugs benefit and do not count toward the $5,000 annual maximum.

» The Plan covers genetic testing when test results will directly affect treatment decisions or frequency of screening for a disease or when results of the test will affect reproductive choices.

» The Plan covers genetic counseling, whether pre- or post-test, and whether occurring in an office, clinic or telephonically. Refer to G. Durable Medical Equipment and Supplies for hearing aid benefits.

### Not Covered:

» Charges for reversal of sterilization, sperm banking, donor ova or sperm for drug therapies related to infertility.

» Separate charges for pre- and post-operative care.

» Please refer to VII. Exclusions.

» Routine foot care, except for covered persons with diabetes, blindness, peripheral vascular disease, peripheral neuropathies and significant neurological conditions such as Parkinson’s disease, Alzheimer’s disease, Multiple Sclerosis and Amyotrophic lateral sclerosis.
### V. Benefit Features Chart

#### Q. Prescription Drugs

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/ Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-day supply (including insulin); available through Pharmacy Benefits Managers’ network pharmacies</td>
<td>$0 copay</td>
<td>$0 copay</td>
<td>$0 copay</td>
<td>100%</td>
</tr>
<tr>
<td>The Plans cover the services listed below at: Select Preventive Medications specified in the Affordable Care Act and Contraceptives in the Generic Plus Category</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td></td>
</tr>
<tr>
<td>Generic Plus (Tier 1) drugs (includes all generic drugs and some low-cost brand drugs if there is no generic drug in a given therapeutic class)</td>
<td>$30 copay</td>
<td>$30 copay</td>
<td>$30 copay</td>
<td></td>
</tr>
<tr>
<td>Formulary brand (Tier 2) drugs (includes all other formulary brand drugs)</td>
<td>$75 copay</td>
<td>$75 copay</td>
<td>$75 copay</td>
<td></td>
</tr>
<tr>
<td>Non-formulary (Tier 3) drugs (includes covered brand drugs not listed on formulary)</td>
<td>Pay the generic copay and difference in cost between the brand drug and the generic drug</td>
<td>Pay the generic copay and difference in cost between the brand drug and the generic drug</td>
<td>Pay the generic copay and difference in cost between the brand drug and the generic drug</td>
<td>Prescriptions are covered in the HSA and at 90% in medical plan, after deductible.</td>
</tr>
<tr>
<td>Purchase of brand drug when chemically equivalent generic is available. The difference in cost does not apply toward the annual out-of-pocket maximum.</td>
<td>3-month supply available for two copays</td>
<td>3-month supply available for two copays</td>
<td>3-month supply available for two copays</td>
<td>Prescriptions are covered in the HSA and at 90% in medical plan, after deductible.</td>
</tr>
<tr>
<td>Drugs purchased by mail order</td>
<td>100% after office visit copay or surgical deductible</td>
<td>100% after office visit copay or surgical deductible</td>
<td>100% after office visit copay or surgical deductible</td>
<td>100%, with office or surgical visit paid at 90%, after deductible</td>
</tr>
<tr>
<td>Implantable and injectable birth control drugs and devices</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

* When in the coinsurance level, pay 10 percent coinsurance based on generic price in addition to difference in cost between the brand drug and the generic drug.
Q. Prescription Drugs (Continued)

Notes:

» If prescription drugs are purchased through an out-of-network pharmacy, then member pays the full cost of the drug at the pharmacy. The claim for these prescriptions must be filed by the member on a paper claim form with the Pharmacy Benefit Manager. Out-of-pocket costs for members on an HSA could also be higher with an out-of-network pharmacy.

» A prescription drug from a retail pharmacy is a 30-day supply or a three-cycle supply of birth control pills for one copay (Generic Plus tier will have a zero copay), or a 90-day supply for three copays. Some medications may be subject to a dispensing limitation per copayment and/or per time period.

» A prescription drug may be purchased from Mail Service Delivery for a three-month supply at a cost of two copayments. For Medica HSA, the standard mail order discount applies.

» Mail order will automatically fill with chemically equivalent generic drugs if available.

» Refills for prescriptions are available when 75% (24th day) has been used for retail purchase and when 65% (60th day) has been used for mail order purchase.

» The Plan covers Federal Legend Pharmaceuticals for the treatment of diseases unless noted as an exclusion.

» The Plan covers a very limited list of over-the-counter medications if prescribed by your physician and included on the drug formulary listing.

» For infertility services, see notes in P. Physician Services.

» Growth hormones do not apply to Prescription Drugs Out-of-Pocket Maximum.

» Special dietary treatment for phenylketonuria (PKU) when prescribed/recommended by a physician does not apply to Prescription Drugs Out-of-Pocket Maximum.

» The formulary is a comprehensive list of preferred drugs selected on the basis of quality and efficacy by a professional committee of physicians and pharmacists. The drug formulary serves as a guide for the provider community by identifying which drugs are covered. It is updated regularly and includes brand name and generic drugs.

» Non-formulary drugs are not on the Pharmacy Benefit Manager’s list of formulary drugs, and a non-formulary copayment applies to these drugs.

» Diabetic meters are covered at 80% through the pharmacy program. See G. Durable Medical Equipment and Supplies.

» Diabetic supplies are covered for Type 1 and Type 2 diabetes as well as for gestational diabetes.

» With a written physician’s prescription, the Plan will cover prescription and over-the-counter nicotine replacement therapies (limited to nicotine patch and nicotine gum) and Sustained Release Bupropion sold under the brand name Zyban, or other trade names designating use only for smoking cessation.

» Dispense as written (DAW) does not override the generic requirement.

» Dispense as written (DAW) does not override the Non-formulary copayment.
V. Benefit Features Chart

Q. Prescription Drugs (Continued)

Over-the-Counter (OTC) Preventive Drug List under Affordable Care Act ($0 copay)
In accordance with requirements put forth through the Affordable Care Act (ACA), the UPlan provides evidence-based Preventive Drug coverage at $0. Refer to the formulary at www.myprime.com for the list of over-the-counter drugs available under your ACA Preventive Drug coverage. The list will be reviewed periodically and is subject to change.

Not Covered:
» The cost of administering the drugs, unless specifically covered under the medical portion of the plan
» The drugs that the federal government has not approved for sale
» Charges for nonprescription (over-the-counter) drugs or medicines; vitamin therapy or treatment; nutritional supplements; over-the-counter appetite suppressants; prescription drugs classified as less than effective by the FDA; biotechnological drug therapy that has not received FDA approval for the specific use being requested, except for off-label use in cancer treatment as specified by law; or prescription drugs that are not administered according to generally accepted standards of practice in the medical community.

» New-to-market biologics and drugs administered by your physician that have recently been approved by the FDA (including approval for a new indication) will not be covered until Medica has reviewed and approved them for coverage.
» Medication that significantly exceeds the cost of an equally effective medication that is already covered by the Plan.
» Drugs for cosmetic purposes
» Refer to N. Non-Covered Drug Products in IV. Pharmacy Benefits
» Informational materials
» Smoking cessation programs, unless Medically Necessary, appropriate treatment, and a plan-approved program
» Replacement of prescription drugs due to loss, damage, or theft
» Please refer to the VII. Exclusions.
## V. Benefit Features Chart

### R. Preventive Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/ Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Plans cover the services listed below at:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Routine physical exams</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100% Deductible does not apply*</td>
</tr>
<tr>
<td>- Routine gynecological exams</td>
<td></td>
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<tr>
<td>- Routine cancer screening</td>
<td></td>
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<tr>
<td>- Laboratory services</td>
<td></td>
<td></td>
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<tr>
<td>- Immunizations and vaccinations; includes those needed for travel</td>
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<tr>
<td>- Routine hearing exams</td>
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<tr>
<td>- Routine eye exams</td>
<td></td>
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<tr>
<td>- Prenatal services</td>
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<tr>
<td>- Postnatal services</td>
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<tr>
<td>- Professional voluntary family planning services</td>
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<tr>
<td>- Lactation counseling and supplies, such as breast pumps</td>
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<tr>
<td>- Counseling for HIV, sexually transmitted diseases, and domestic or other personal violence</td>
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<td></td>
</tr>
<tr>
<td>- Women’s preventive health services including mammograms (includes 3D mammograms), screenings for cervical cancer, human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling for human immunodeficiency virus (HIV), BRCA genetic testing and related genetic counseling (when appropriate), and sterilization.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Out-of-network</td>
<td></td>
<td></td>
<td></td>
<td>For out-of-network coverage, refer to N. Out-of-Network Care</td>
</tr>
</tbody>
</table>

* Labor, delivery, and postnatal services are not considered preventive under HSA guidelines; therefore, services will be subject to the deductible.

**Notes:**
- For routine eye care, members may self refer to any providers in the vision care services network.
- Coverage is limited to one (1) routine eye exam and one (1) routine hearing exam per plan year.
- Colonoscopy, including non-invasive colonoscopy, covered at 100%, unless a specific condition exists (i.e., Crohn’s), in which case a copay would apply.
- If services are determined not to be preventive, a deductible will apply to laboratory services and a copay to the office visit.

**Not Covered:**
- Charges for physical exams for the purpose of obtaining employment or insurance
- Charges for recreational or educational therapy, or forms of non-medical self-care or self-help training, including, but not limited to, health club memberships, smoking cessation programs (unless medically necessary, appropriate treatment, and a plan-approved program)
- Charges for lenses, frames, contact lenses or other fabricated optical devices or professional services for the fitting and/or supply thereof (except when eligible under G. Durable Medical Equipment and Supplies), including the treatment of refractive errors such as radial keratotomy
- Please refer to the VII. Exclusions.
## V. Benefit Features Chart

### S. Reconstructive Surgery

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/ Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Plans cover the following services at:</td>
<td>Inpatient: 100% coverage after deductible</td>
<td>Inpatient: 100% coverage after deductible</td>
<td>Inpatient: 100% coverage after deductible</td>
<td>Inpatient: 90% after deductible</td>
</tr>
<tr>
<td>» Surgery to repair a defect caused by an accidental injury</td>
<td>Outpatient: 100% coverage after deductible</td>
<td>Outpatient: 100% coverage after deductible</td>
<td>Outpatient: 100% coverage after deductible</td>
<td>Outpatient: 90% after deductible</td>
</tr>
<tr>
<td>» Reconstructive surgery incidental to or following: surgery resulting from injury, sickness, or disease of that part of the body</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>» Reconstructive surgery performed on an eligible dependent child who has a congenital disease or anomaly that has caused a functional defect, as determined by the attending physician</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Reconstructive surgery to correct a child’s birth defect (other than a developmental defect), for dependent children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Treatment of cleft lip and palate for a child under age 18 (refer to F. Dental Care)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Elimination or maximum feasible treatment of port wine stain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Out-of-network**

For out-of-network coverage, refer to N. Out-of-Network Care

**Note:**

» See Z. Annual Notifications in this V. Benefit Features section.

**Not Covered:**

» Charges for cosmetic health services or any related services, except as provided above

» Please refer to the VII. Exclusions.
### T. Rehabilitative and Habilitative Services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/ Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitative or habilitative physical, speech, and occupational therapy services received in a clinic, office, or as an outpatient</td>
<td>100% after $25 copay per visit</td>
<td>100% after $20 copay per visit</td>
<td>100% after $40 copay per visit</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Massage therapy that is medically necessary performed in conjunction with other treatment/modalities by a licensed practitioner and is part of a treatment plan prescribed by a licensed physician</td>
<td>100% after $25 copay per visit</td>
<td>100% after $20 copay per visit</td>
<td>100% after $40 copay per visit</td>
<td>90% after deductible</td>
</tr>
</tbody>
</table>

**Out-of-network** For out-of-network coverage, refer to N. Out-of-Network Care

**Notes:**

» Physical, occupational, and speech therapy services are covered if the rehabilitative care is to correct the effects of illness or injury or if the habilitative care is rendered for congenital, developmental, or medical conditions that have limited the successful initiation of normal speech and motor development. To be considered habilitative, functional improvement and measurable progress must be made toward achieving functional goals within a predictable period of time toward a Plan Member’s maximum potential ability.

» Rehabilitative therapy is covered to restore function after an illness or injury provided for the purpose of obtaining significant functional improvement within a predictable period of time, toward a Plan Member’s maximum potential to perform functional daily living activities.

**Not Covered:**

» Charges for recreational or educational therapy, or forms of non-medical self-care or self-help training, including, but not limited to, health club memberships

» Charges for maintenance or custodial therapy; charges for rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time

» Please refer to the VII. Exclusions.
### V. Benefit Features Chart

#### U. Skilled Nursing Facilities

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/ Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Plans cover the services listed below at:</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>» Skilled Care ordered by a physician</td>
<td></td>
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<tr>
<td>» Room and board</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>» General nursing care</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>» Prescription Drugs or other medications and supplies used during a covered admission, and billed through the skilled nursing facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Physical, occupational, and speech therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Respiratory therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Out-of-network**

For out-of-network coverage, refer to N. Out-of-Network Care

**Not Covered:**

Please refer to the **VII. Exclusions.**
V. Benefit Features Chart

V. Specified Out-Of-Network Services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Plans cover the following services at the in-network coverage level when you receive them from an Out-of-Network provider:</td>
<td>Coverage level is same as corresponding benefit, depending on type of service provided, such as Physician Services.</td>
<td></td>
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</tr>
<tr>
<td>» Voluntary family planning of the conception and bearing of children</td>
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<tr>
<td>» Provider visits and tests to make a diagnosis of infertility</td>
<td></td>
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</tr>
<tr>
<td>» Testing and treatment of sexually transmitted diseases</td>
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<td></td>
</tr>
<tr>
<td>» Testing for AIDS and other HIV-related-conditions</td>
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</tr>
</tbody>
</table>
Notes:

» Covered outpatient professional services for substance abuse must be provided by a program licensed by the local Health and Human Services Department, and can include the following:
  • Diagnostic evaluations;
  • Individual, group, family, and multi-family therapy provided in an out-patient setting;
  • Medication-assisted treatment—the use of medications in conjunction with counseling and behavioral therapies to help maintain sobriety, prevent relapse, and reduce craving in order to sustain recovery including methadone and buprenorphine treatment.

» Covered inpatient services for substance abuse must be provided in a hospital or other licensed residential treatment center, and can include the following:
  • Detoxification services;
  • Semi-private room and board;
  • Attending physician’s services;
  • Hospital or facility-based professional services;
  • Group and individual counseling, client education, and other services specific to substance abuse rehabilitation.

• In-network benefits are available when members receive services from providers in their plan’s substance abuse network.
• Methadone maintenance therapy and other equivalents are covered with a copay or coinsurance based on the plan option.

Not Covered:

» Charges for services or confinements that are ordered by a court or law enforcement officer that the Plan Administrator determines are not Medically Necessary

» Charges for services that are normally provided without charge, including services of the clergy

» Charges for services to hold or confine a person under chemical influence when no medical services are required, regardless of where the services are received

» Telephonic substance abuse treatment services

» Please refer to the VII. Exclusions
X. Transplant Services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/ Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
<th>Medica HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Plans cover the services listed below at:</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>100% coverage after deductible</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Transplants and certain related services for the following:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Bone Marrow / Stem Cell Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Cornea</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Heart</td>
<td></td>
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<tr>
<td>» Heart-Lung</td>
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<tr>
<td>» Kidney</td>
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<tr>
<td>» Liver</td>
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<tr>
<td>» Lung</td>
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<td></td>
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<tr>
<td>» Pancreas</td>
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</tr>
</tbody>
</table>

Out-of-network

For out-of-network coverage, refer to N. Out-of-Network Care

Transportation and lodging reimbursement

Transportation and lodging reimbursement is available for reasonable and necessary expenses up to a $10,000 lifetime maximum, as described below

d. The $10,000 lifetime maximum per covered person is for all transportation and lodging expenses incurred by you and your companion(s)
e. Meals are not reimbursable under this benefit
f. You are responsible for paying all amounts not reimbursed under this benefit
g. Any amount not reimbursed does not count toward satisfaction of your deductible or your out-of-pocket maximum
h. Expenses incurred for out-of-network services are not eligible for this reimbursement

Notes:

» Contact your Medical Claims Administrator for limitations and other details.

» To receive in-network benefits, members seeking transplant services must work with the Claims Administrator to coordinate with Center of Excellence facilities where available or Transplant Access Program.

» Transportation and lodging reimbursement for you and a companion is covered when you receive approved transplant services at a designated facility that is more than 50 miles from where you live

a. Transportation for you and one companion traveling on the same day to or from a designated facility for transplant services for pre-transplant, transplant, and post-transplant services

b. Per diem reimbursement for lodging for you (while not confined) up to $150 or per diem for you and one companion up to $300

c. For a minor child, reimbursement for transportation and lodging for two companions up to $300 per diem

d. The $10,000 lifetime maximum per covered person is for all transportation and lodging expenses incurred by you and your companion(s)

e. Meals are not reimbursable under this benefit

Not covered:

» Donor expenses when recipient is not covered under this plan

» Donor complications after organ is removed when recipient is not covered under this plan

» Please refer to the VII. Exclusions.
V. Benefit Features Chart

Y. Harmful Use of Medical Services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medica Elect/ Essential Medica Choice Regional</th>
<th>Medica ACO Plan</th>
<th>Medica Choice National</th>
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</thead>
</table>

This section describes what Medica will do if it is determined that you are receiving health services or prescription drugs in a quantity or manner that may harm your health.

**When this section applies:**
After Medica notifies you that this section applies, you have 30 days to choose one network physician, hospital, and pharmacy to be your coordinating health care providers.

If you do not choose your coordinating health care providers within 30 days, Medica will choose for you. Your in-network benefits are then restricted to services provided by or arranged through your coordinating health care providers.

If the Claims Administrators identify an individual as a result of misuse of prescription drugs, the University of Minnesota authorizes the Claims Administrators to release the name to the appropriate case manager at the medical plan or pharmacy benefits manager.

Failure to receive services from or through your coordinating health care providers will result in denial of coverage.

You must obtain a referral from your coordinating health care provider if your condition requires care or treatment from a provider other than your coordinating health care provider.

Medica will send you specific information about:

1. How to obtain approval for benefits not available from your coordinating health care providers; and
2. How to obtain emergency care; and
3. When these restrictions end.
The Federal Women’s Health and Cancer Rights Act of 1998 requires group health plans such as this Plan to provide certain benefits if a member chooses reconstructive surgery after a mastectomy. The federal law requires coverage for the following services:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema)

Services are provided in a manner determined in consultation with the physician and patient. Coverage is provided on the same basis as any other illness.

Under federal law, group health plans such as this Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child.

- May not restrict hospital stay to less than 48 hours following a vaginal delivery
- May not restrict hospital stay to less than 96 hours following a caesarean section

However, Federal law generally does not prohibit the mother’s or newborn child’s attending provider, after consultation with the mother, from discharging the mother or her newborn child earlier than 48 hours or 96 hours, as applicable.
You may need prior authorization (approval in advance) from Medica before you receive certain services or supplies. When reviewing your request for prior authorization, Medica uses written procedures and criteria to determine whether a particular service or supply is medically necessary and is a covered benefit. This applies even when the services are provided by a network provider or provided as the result of a referral or direction by a network provider. To verify whether a specific service or supply requires prior authorization, please call the specific customer service phone number for your plan found on the back of your ID card.

Emergency services do not require prior authorization.

You do not require prior authorization to obtain access to obstetrical or gynecological care from a network provider who specializes in obstetrics or gynecology. However, certain specific services provided by that network provider may require prior authorization.

You, someone on your behalf, or your attending provider may contact Customer Service to request prior authorization. Your network provider will contact Medica to request prior authorization for a service or supply. If a network provider fails to request prior authorization after you have consulted with them about services requiring prior authorization, you will not be penalized for this failure.

You must contact Customer Service to request prior authorization for services or supplies received from a non-network provider.

We recommend that you confirm with Customer Service that Medica has prior authorized all services and supplies requiring prior authorization, including those received from a network provider.

Prior authorization is required for a number of services and supplies, including but not limited to those described below:

- Solid organ and blood marrow transplant services — this prior authorization must be obtained before the transplant workup is initiated;
- In-network benefits for services from non-network providers, with the exception of emergency services;
- Certain reconstructive or restorative surgery procedures;
- Certain drugs and biologics;
- Certain home health care services;
- Certain medical supplies and durable medical equipment;
- Certain mental health services;
- Certain substance abuse services;
- Certain outpatient surgical procedures;
- Certain genetic tests;
- Certain imaging services (for example: PET scans and proton beam therapy); and
- Skilled nursing facility services.

Pregnancy/maternity care services do not require prior authorization and are covered at the appropriate in-network or out-of-network benefit level.

This is not a complete list of all services and supplies that may require prior authorization.

Medica will review your request for prior authorization and respond to you and your attending provider within a reasonable time period appropriate to your medical circumstances, provided all information reasonably necessary to make a decision has been given to Medica.
The Plan excludes from benefits coverage and does not pay for:

1. Charges for services that are eligible for payment under a Workers’ Compensation law, employer liability law, or any similar law
2. Charges that are eligible, paid, or payable under any medical payment, personal injury protection, automobile, or other coverage that is payable without regard to fault, including charges for services that are applied toward any Copayment or Coinsurance requirement of such a policy
3. Services that are rendered to a Member who also has other primary insurance coverage for those services and who does not provide the Claims Administrator the necessary information to pursue coordination of benefits, as required by the Plan
4. The portion of eligible services and supplies paid or payable under Medicare
5. Charges for services for or related to reconstructive surgery or cosmetic health services, except as specified in the Benefit Features section
6. Charges for any treatments, services, or supplies that the Claims Administrator determines are not Medically Necessary based on its internal standards
7. Charges for any treatment, service, or supply that is Investigational or Experimental as determined by the Claims Administrator
8. Charges for care that is custodial
9. Charges for care that is not normally provided as Preventive care (such as heart scans)
10. Charges for care that is not normally provided as Treatment of an Illness, including, but not limited to, virtual colonoscopy
11. Charges for therapeutic acupuncture except for conditions that meet Medically Necessary criteria
12. Charges for gender reassignment surgery, sex hormones related to surgery, related preparation and follow-up treatment, care, and counseling, unless Medically Necessary
13. Charges for marital, family, or other counseling or training services, religious counseling or sex therapy rendered in the absence of a significant mental disorder except as provided in the V. Benefit Features section under Mental Health
14. Charges for recreational or educational therapy, or forms of non-medical self-care or self-help training, including, but not limited to, health club memberships and smoking cessation programs
15. Charges for lenses, frames, contact lenses or other fabricated optical devices or professional services for the fitting or supply thereof
16. Charges for lasik, keratotomy, and keratorefractive surgeries
17. Charges for services that are normally provided without charge, including services of the clergy
18. Charges for autopsies
19. Nonprescription and/or over-the-counter drugs or medicines, except as specified in the UPan Prescription Drug Formulary as a covered over-the-counter drug, vitamin therapy, vitamin therapy or treatment, appetite suppressants, prescription drugs that have not been classified as effective by the FDA, bioengineered drug therapy that has not received FDA approval for the specific use being requested, except for off-label use in cancer treatment, as specified by law, and prescription drugs that are not administered according to generally accepted standards of practice in the medical community
20. Donor charges for major organ and bone marrow transplants when the recipient is not covered under the Plan; including all transplant-related follow-up treatment, exams, drugs and drug therapies, and complications from transplants
VII. Exclusions

21. Charges for services a Provider gives him/herself or a close relative (such as spouse, brother, sister, parent, or child)

22. Charges for dental or oral care except for those specified in the V. Benefit Features section

23. Charges for any appliance or service for or related to dental implants, including hospital charges

24. Charges for personal comfort items such as telephone, television, barber, beauty services, and guest services

25. Charges for services and supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, exercise equipment, air purifiers, air conditioners, dehumidifiers, heat appliances, water purifiers, hypoallergenic mattresses, waterbeds, vehicle lifts, computers and related equipment, and home blood pressure kits

26. Nonprescription and over-the-counter charges for arch supports, foot orthotics or orthopedic shoes, including biomechanical evaluation and negative foot mold impressions, except as specified in the V. Benefit Features section

27. Charges for or related to transportation other than ambulance service to the nearest medical facility equipped to treat the Illness or injury, except as specified in the V. Benefit Features section

28. Charges for travel, transportation, or living expenses, except as described in the V. Benefit Features, Section X. Transplant Services

29. Charges for services provided before your coverage is effective or after your coverage terminates even though your Illness started while coverage was in force

30. Charges for private-duty nursing, except as described in I. Home Health Care coverage.

31. Charges for weight loss programs, including program fees or dues, nutritional supplements, food, over-the-counter appetite suppressants, vitamins, and exercise therapy

32. Charges for maintenance or custodial therapy; charges for rehabilitation services, such as physical, occupational, and speech therapy that are not expected to make measurable or sustainable improvement within a reasonable period of time

33. Charges for nursing services to administer home infusion therapy when the patient or other caregiver can be successfully trained to administer therapy; services that do not involve direct patient contact, such as delivery charges and record keeping

34. Charges for inpatient admission to the hospital for diagnostic tests that can be performed on an outpatient basis

35. Charges for injections which can be self-administered; however, in some cases the prescription drug may be covered as specified in the V. Benefit Features section

36. Charges for services for or related to growth hormone, except replacement therapy that is eligible for conditions that meet Medical Necessity criteria as determined by the Claims Administrator prior to receipt of the services

37. Charges for voluntary reversal of sterilization

38. Charges for long-term storage of ova or sperm

39. Massage therapy for the purpose of a Member’s comfort or convenience

40. The portion of a billed charge for an otherwise covered service by a provider that is in excess of the fair and reasonable charges

41. Nutritional supplements, over-the-counter electrolyte supplements and infant formula, except as required by Minnesota law Chapter 62A.26 for PKU treatment

42. Genetic counseling and genetics studies which are not Medically Necessary

43. Services for genetic screening and testing except when a) recommended by a genetic counselor as predictive of a disease process and treatment standards of care exist for the disease process, or b) reproductive choices would be made based on the test findings
44. Intensive behavior therapy treatment programs: Services for or related to intensive behavior therapy treatment programs for the treatment of autism spectrum disorders, except when considered Medically Necessary in addition to meeting the Plan’s criteria

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

46. Charges for elective, non-emergency home childbirth deliveries

47. Separate charges for childbirth education classes when billed separately

48. Services for vision therapy, except for limited services that are considered Medically Necessary based on the guidelines of the plan

49. Telephonic substance abuse treatment services, unless such services are provided in accordance with the Claims Administrator’s telemedicine policies and procedures

50. Services for telephone psychotherapy, unless such services are provided as a behavioral health service in accordance with the Medical Claims Administrator’s telemedicine policies and procedures

51. Services solely for or related to the treatment of snoring

52. Chemotherapy or radiation therapy, together with all related services, supplies, drugs, and aftercare, when the administration of such is expected to result in damage to or suppression of the bone marrow, the blood or blood forming systems, warranting or requiring receipt of autologous, allogeneic or syngeneic stem cells, whether derived from the bone marrow or the peripheral blood, unless the procedure is specifically listed as covered

53. Charges for treatment, equipment, drugs, and devices that the Claims Administrator determines do not meet generally accepted standards of practice in the medical community for cancer and allergy testing and treatment

54. Charges for services for or related to systemic candidiasis, homeopathy, immunoaugmentative therapy, or chelation therapy that the Claims Administrator determines is not Medically Necessary

55. Charges for physical exams for purpose of obtaining employment, licensure, or insurance

56. Services to hold or confine a person under chemical influence when no medical services are required regardless of where the services are received

57. Services provided to treat injuries or illness as a result of committing a crime or attempting to commit a crime

58. Laboratory testing that has been performed in response to direct-to-consumer marketing and not under the direction of a physician

59. Enteral feedings, unless they are the sole source of nutrition; however, enteral feedings of standard infant formulas, standard baby food and regular grocery products used in blenderized formulas are excluded regardless of whether they are the sole source of nutrition

60. Charges for Orthognathic Surgery done for cosmetic purposes

61. Charges and services that are rendered to a member by a non-licensed provider

62. Routine foot care, except for covered persons with diabetes, blindness, peripheral vascular disease, peripheral neuropathies and significant neurological conditions such as Parkinson’s disease, Alzheimer’s disease, Multiple Sclerosis and Amyotrophic lateral sclerosis.

63. Services related to adoption

64. Any form, mixture or preparation of cannabis for medical or therapeutic use and any device or supplies related to its administration.

VII. Exclusions
VIII. Definitions

Miscellaneous Plan Terminology

Allowed Amount
A set amount the Plan agrees to pay for a service or product when provided by a participating in-network provider. When the charges of an out-of-network provider are higher than the allowed amount, the member is generally responsible for the difference.

Authorized care outside the Service Area: For an illness, injury, or condition for which services may be required and the member will be temporarily leaving the service area, the Plan covers urgently needed care from non-network providers if the member is under the care of a PCC or treating physician who has authorized that care. Coverage may include professional services from a non-network physician and hospital services, which are for scheduled care which is immediately required and cannot be delayed. Plan covers at in-network benefit level.

Benefit Features chart
A chart in Section V. of this Summary of Benefits which list specific benefit amounts for covered services.

Biologics
Any of a wide range of products designed to replicate natural substances in the body, including but not limited to, products produced using biotechnology. Biologics include, but are not limited to, vaccines, blood and blood components or products, cellular and gene therapy products, tissue and tissue products, allergens, recombinant therapeutic proteins, monoclonal antibodies, cytokines, growth factors, immunomodulators, and additional biological products regulated by the U.S. Food and Drug Administration and related agencies.

Care Network or Care System
A Care Network or Care System is a network of participating health care providers that includes primary care clinics, primary care physicians, specialists, hospitals, and other health care professionals who work together to serve the Member. Each primary care clinic participates in only one Care Network or Care System. The primary care clinic’s Care Network or Care System establishes the requirements, if any, for accessing specialty care that the Member must follow to receive in-network benefits.

Centers of Excellence
The “Centers of Excellence” initiative relies on evidence-based care to help ensure that UPlan Medical Program members get safe, quality care related to certain complex procedures. This initiative identifies experienced surgeons and comprehensive surgical facilities that provide services related to transplants and bariatric care, including surgery for morbid obesity.

Through an application process, surgeons and hospitals need to meet certain qualifications in order to achieve an approved designation for Centers of Excellence.

Claims and Network Administrator
Medica Self-Insured (MSI) is the entity that handle the day-to-day operations of the UPlan medical plan options, along with the pharmacy benefit manager, Prime Therapeutics and Fairview Specialty Pharmacy, and the health improvement program administrator, Staywell. Claims Administrators contract with providers, provide customer service, adjudicate claims, and provide a variety of other services to enrollees on behalf of the Plan Sponsor (the University of Minnesota).

Coinsurance
The percentage of the allowed amount you must pay for certain covered services. Coinsurance applies after any applicable deductible and copayments. Coinsurance no longer applies once you have reached an applicable out-of-pocket maximum.

Continuous Coverage
The maintenance of continuous and uninterrupted creditable coverage by an eligible employee or dependent. An eligible employee or dependent is considered to have maintained continuous coverage if the enrollment date for coverage is within 63 days of the termination of his or her creditable coverage.
VIII. Definitions

**Convenience care/retail health clinic**
A health care clinic located in a setting such as a retail store, grocery store, or pharmacy, that provides treatment of common illnesses and certain preventive health care services.

**Copayment**
A set dollar amount for which the member is responsible. Copayments are generally due at the time the service is rendered, or a supply or drug is provided. Also called “copays.”

**Cosmetic**
Services and procedures that improve physical appearance but do not correct or improve a physiological function and that are not medically necessary, unless the service or procedure meets the definition of reconstructive.

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

**Creditable Coverage**
Health coverage provided through an individual policy, a self-funded or fully-insured group health plan offered by a public or private employer, medical assistance, general assistance medical care, the TRICARE, Federal Employees Health Benefit Plan (FEHBP), Medical care program of the Indian Health Service of a tribal organization, a state health benefit risk pool, or a Peace Corps health plan.

**Custodial Care**
Services that the Claims Administrator determines are for the primary purpose of meeting personal needs. These services can be provided by persons without professional skills or training. Custodial care does not include skilled care. Custodial care includes giving medicine that can usually be taken without help, preparing special foods, and helping you to walk, get in and out of bed, dress, eat, bathe, and use the toilet.

**Deductible**
The amount you must pay toward the allowed amount for certain covered services each year before the Claims Administrator begins to pay benefits.

**Durable Medical Equipment**
Medically Necessary equipment that the Claims Administrator determines is:
1. Able to withstand repeated use
2. Used primarily for a medical purpose
3. Useful only to a person who is ill
4. Prescribed by a physician

Durable medical equipment does not include such things as:
1. Vehicle lifts
2. Waterbeds
3. Air conditioners
4. Heat appliances
5. Dehumidifiers
6. Exercise equipment

**Emergency Care**
An emergency is 1) the sudden, unexpected onset of illness or injury that, if left untreated or unattended until the next available clinic hours, would result in hospitalization or death, or 2) condition requiring professional health services immediately that a prudent layperson would believe necessary to preserve life or stabilize health.

**Foot Orthotic**
A foot orthotic is a rigid or semi-rigid orthopedic appliance or apparatus worn to support, align, and/or correct deformities of the lower extremity.

**Formulary**
A comprehensive list of preferred drugs selected on the basis of quality and efficacy by a professional committee of physicians and pharmacists.
VIII. Definitions

**HSA: Health Savings Account**
An HSA is an amount of dollars set aside to pay for eligible expenses incurred by an enrollee. For employees who receive an employer contribution toward the cost of their coverage, the HSA is funded by the University. For anyone not receiving an employer contribution, the rates are adjusted to account for that. In an HSA, the employee owns the account and can make pre-tax contributions to the HSA to be invested. The employee also has the option to save the HSA contributions to use for future expenses. Medica HSA is the only UPlan option that includes an HSA.

**Hospice Care**
A coordinated set of services provided at home or in an institutional setting for covered individuals suffering from a terminal disease or condition with a life expectancy of six months or less.

**Illness**
A sickness, injury, pregnancy, mental illness, chemical dependency, or condition involving a physical disorder.

**In-Network**
A group of participating providers under contract with a Claims Administrator to provide services to members of the Plan. Alternatively, the services received from network providers.

**Inpatient Hospital Claim**
Any claim received with a room and board charge would be covered as an inpatient stay.

**Investigational**
As determined by the Claims Administrator, a drug, device, or medical treatment or procedure is investigational if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes.

**Lifetime Maximum**
The cumulative maximum payable for covered services incurred by you during your lifetime or by each of your dependents during the dependent’s lifetime under all health plan options sponsored by the University of Minnesota. Lifetime maximum does not include amounts which are your responsibility such as deductibles, coinsurance, copayments, penalties, and other amounts.

**Mail Service Delivery**
A cost-effective delivery system that provides prescribed medications to plan participants via UPS or first class U.S. mail.

**Medically Necessary**
Eligible medical and hospital services that the Claims Administrator determines are appropriate and necessary based on its internal standards.

**Members**
Members are eligible employees and their dependents who are enrolled in the Plan.

**Nonparticipating Provider**
Providers who have not signed an agreement with the Claims Administrator or its subsidiaries.

**Out-of-Network Care**
Out-of-network care is defined as care received from a nonparticipating provider. All of the medical plan options include out-of-network coverage for eligible medical services provided by a licensed health care provider not participating in the plans’ networks. Coverage will be at a 70% coinsurance level after a deductible is satisfied. Refer to the V. Benefit Features Chart for the applicable deductible amount.

**Out-of-Pocket Maximum**
The most each person must pay each year toward the allowed amount for covered services. After a person reaches the out-of-pocket maximum, the Plan pays 100% of the allowed amount for covered services for that person for the rest of the year.

**Participating Transplant Center**
A hospital or other institution that has contracted with the Claims Administrator to provide organ or bone marrow transplant, stem cell support, all related services, and aftercare.
VIII. Definitions

**Plan**
The plan of benefits established by the UPlan Sponsor.

**Plan Sponsor**
Board of Regents, University of Minnesota.

**Plan Year**
The period from the effective date on January 1 to the end of the year on December 31.

**Prescription Medication Out-of-Pocket Maximum**
The most you must pay toward the allowed amount for prescription medications per benefit year.

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

**Preventive Care**
Management of care of a member directed toward the prevention or early detection of disease. Preventive care includes such services as routine physicals, routine screenings, and vaccinations. Preventive cancer screenings are routine, scheduled screenings recommended for all members of a specific population. These include screening for breast cancer, cervical cancer, ovarian cancer, colon cancer, and prostate cancer. These screenings are billed with the preventive ICD-9 code.

Services provided to a member seeking care for a complaint or condition, or as follow-up care to a condition are not preventive. Symptom-based cancer screenings that are performed because symptoms, such as rectal bleeding, coughing up blood, or skin abnormalities are present are NOT considered preventive. These screenings are billed with the diagnosis code corresponding to the condition or disease.

**Primary Care**
Routine medical care normally provided in a doctor’s office. Primary Care includes Family Medicine, Internal Medicine, Obstetrics/Gynecology, and Pediatrics.

**Prior Authorization**
The Claims Administrator’s approval for coverage of health services before they are provided.

**Provider**
Any person, facility, or other program that provides covered services within the scope of the provider’s license, certification, registration, or training.

**Reconstructive**
Surgery to rebuild or correct a:
1. Body part when such surgery is incidental or following surgery resulting from injury, sickness or disease of the involved body part, or
2. Congenital disease or anomaly, which has resulted in a functional defect as determined by your physician.

In the case of mastectomy, surgery to reconstruct the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance shall be considered reconstructive.

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

**Self-referral**
When a member seeks medical services from a provider without a referral from a designated primary care provider or clinic. Some UPlan options allow self-referral and others do not. See III. Plan Descriptions for more information.

**Semiprivate Room**
A room with more than one bed.
VIII. Definitions

**Skilled Care**
Services that are Medically Necessary and must be provided by registered nurses or other eligible providers. 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.

Such services shall not be regarded as skilled nursing services, 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 (services which include skilled and non-skilled components) are covered under the Plan.

**Social Security Disability**
Total disability as determined by the Social Security Administration.

**Specialty Medications**
Specialty pharmacy medications are bio-engineered to treat specific diseases and are often used for long-term disease management or to treat chronic diseases. These medications are usually administered through injections and include special requirements for handling and administration.

**Spouse**
Person to whom the employee is legally married.

**Substance-Related Disorders**
Addictive physical or emotional conditions or illnesses caused by habitual use of alcohol or drugs.

**Supply**
Equipment that must be Medically Necessary for the medical treatment or diagnosis of an illness or injury, or to improve functioning of a malformed body part. Supplies are not reusable and usually last for less than one (1) year.

**Treatment**
The management and care of a patient for the purpose of combating an illness. Treatment includes medical and surgical care, diagnostic evaluation, giving medical advice, monitoring, and taking medication.

**Urgent Care**
Urgent care includes services to 1) treat an unexpected illness or injury that is not life-threatening but requires outpatient medical care that cannot be postponed, or 2) is the result of an acute injury or illness that is severe or painful enough to lead a prudent layperson to believe that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of his or her health.

**Usual & Customary (U&C) Charges**
Defined by Claims Administrator, the charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area. (Also called Reasonable and Customary charge or Usual and Customary and Reasonable charge)

**Virtual Care**
Professional evaluation and medical management services provided to members through email, telephone, or webcam. Virtual care includes interactive audiovisual telehealth services. Virtual care is used to address non-urgent medical symptoms for members describing new or ongoing symptoms to which providers respond with substantive medical advice.

**You or Your**
The employee named on the identification (ID) card and any covered dependents.
When you are traveling or your dependent is a student attending college outside of the Plan’s service area, you may still receive in-network benefits for medical services if you use a provider in the designated network from Medica. To be eligible for this benefit, your permanent residence must be within the plan’s service area. Contact your Claims Administrator to determine if you or your dependents are eligible for the travel program.

Medica offers a travel program for members in Medica Elect/Essential, Medica ACO Plan, and Medica Choice Regional.

This program makes it possible for you or your covered dependents to access the UnitedHealthcare Options PPO network when traveling outside of Medica’s service area and receive in-network benefits. However, chiropractic and transplants are not part of the travel program. Your out-of-network/emergency benefit will apply for these services.

To locate a UnitedHealthcare Options PPO network provider, visit www.medica.com/uofm and then click on the link for Travel Program to access the travel network. Or you may call the customer service phone number listed on the back of your Medica member ID card.

Note:

» The travel program is already included in the Medica Choice National and Medica HSA plan options. Medica Choice National and Medica HSA also allow a member to live outside of the service area.

» Students covered by Medica Elect/Essential who are attending college within Medica’s service area who have no in-network provider access should contact Employee Benefits to complete a waiver form. This is not available to Medica ACO Plan members as all services will be coordinated by the ACO provider.
X. Global Medical Assistance Program

UPlan members and their covered family members are automatically enrolled in UnitedHealthcare Global, a global medical assistance program. This program provides multilingual assistance 24-hours a day plus immediate help in a travel-related emergency, whether you are 100 miles from home or traveling internationally.

A. Medical and Dental Help 24/7
UnitedHealthcare Global provides worldwide medical and dental referrals 24 hours a day, seven days a week. They will assist you with locating the nearest appropriate health care provider or coordinating admission into a hospital. UnitedHealthcare Global will contact your treating physician to assess your condition and treatment plans to ensure your safe recovery and update your family, employer, and personal physician as appropriate. UnitedHealthcare Global will help you until you have returned home or have received final treatment.

International hospital and medical expenses through UnitedHealthcare Global are covered as in-network benefits, subject to the usual terms and conditions of your UPlan coverage for emergency and urgent care. You are still responsible for any copayments, coinsurance, or deductibles that are incurred with treatment. If care does not go through UnitedHealthcare Global, it would be considered out-of-network.

B. Political and Natural Disaster Evacuation Coverage
UnitedHealthcare Global will help make flight arrangements, including tickets, visas, and logistical arrangements in case you are involved in a political or natural disaster emergency. They will provide transportation to a safe departure point if you need to be evacuated due to a political or security situation or a natural disaster. The service continues to offer medical evacuation if your doctor and UnitedHealthcare Global determine that you need to be transported to another facility due to an injury or illness.

C. Travel Assistance Services
For help with medical, travel, and security problems, call UnitedHealthcare Global using one of the country-specific toll-free numbers printed on the back of the card. If you are in a country not listed, call the Emergency Response Center collect at 1-410-453-6330. A multilingual assistance coordinator will ask for your name, your company or group name, the group number shown on your ID card, and a description of your situation.

You are encouraged to go to the Employee Benefits website at humanresources.umn.edu/medical-plans/unitedhealthcare-global for a summary of the program definitions, conditions, and limitations and a link to UnitedHealthcare Global.

Set up an account and take advantage of all the travel benefits including medical intelligence reports, travel guides, and world watch— including security alerts, travel registry, and pre-travel checklists. You can also turn to UnitedHealthcare Global to replace lost or stolen passports or tickets, for an emergency cash advance, or translation services.

If you need an ID card for yourself or for another covered family member, log in to your account and print one from the website.
When you want fast and affordable medical care for certain common ailments that have specific treatments, you can access walk-in clinics such as Gopher Quick Clinic on the Twin Cities campus, WellCare on the Duluth campus, and other walk-in clinics, such as the MinuteClinic locations in the Twin Cities. The clinics are in-network providers for the UPlan Medical Program options. However, Gopher Quick Clinic is not available to Medica ACO members except for participants in the VantagePlus network (Fairview, HealthEast, North Memorial, and popular independent clinics including Boynton Health and University of Minnesota Health).

The walk-in clinics do not require appointments or referrals, and the visits generally take about 15 minutes. You will have a $15 to $20 copayment per visit for treatments and screenings depending on your medical plan selection. There is no copayment for immunizations. In Medica HSA, the cost of the visit is applied to the deductible, or if funds are available, it can be paid out of the account balance.

The clinics are staffed by board-certified physician assistants or nurse practitioners who are trained to diagnose, treat, and provide prescriptions when needed. If necessary, they will refer you to your regular health care provider.

**A. Gopher Quick Clinic on Twin Cities Campus**
The Gopher Quick Clinic offers fast, convenient health care services to faculty, staff, and their dependents who are enrolled in a UPlan medical plan.

Gopher Quick Clinic is provided through Boynton Health and located on the third floor in Boynton on the East Bank campus and in 109 Coffey Hall on the St. Paul campus. For more information, refer to Boynton’s website at www.bhs.umn.edu.

**B. WellCare on Duluth Campus**
UMD WellCare (located in the Employee Health and Wellbeing Center, 247 Kirby Plaza) includes visits for minor, acute illnesses, immunizations, and simple checks (such as blood pressure). The registered nurse providing services at WellCare works with the medical director at the UMD Health Service. For more information, refer to the website at d.umn.edu/employee-health-wellbeing-center.

**C. Medica CallLink Nurse Line**
The nurseline service is with Medica CallLink. Medica CallLink connects you with an experienced nurse or advisor for information and advice about general health issues, self-care for minor injuries and illnesses, or finding a new provider. CallLink is open 24-hours a day. Look for the CallLink number on the back of your medical ID card.
XII. Virtual Care

Virtual care, also known as online care or an e-visit, is a convenient way to get care for many common conditions. You can connect with a provider from your computer or mobile device to get a diagnosis, treatment plan and prescription (if needed).

Virtual care may be a timesaving option for common conditions like:
- Allergies
- Bladder infection
- Bronchitis
- Cold and cough
- Ear pain
- Flu
- High blood pressure
- Migraines
- Pink eye
- Rashes
- Sinus infection
- Other non-urgent, common health conditions

**With a virtual care visit, you:**
- Save time – avoid a trip to the doctor’s office and get care from the comfort of your home, work, or wherever you are
- Initiate the visit at your convenience – no appointment needed
- Get care when you need it – visits are often available after clinic hours, sometimes even 24/7
- Save money – a virtual care visit costs less than a regular visit to the doctor’s office

**Your benefits**
Your UPlan medical plan covers virtual care visits with providers that are in your plan’s network. Unless otherwise noted, your costs for a virtual care visit are the same as for a walk-in, convenience care clinic, which would be $15 or $20, depending on your plan, or applied to your deductible if your plan is Medica HSA. Medica National Choice members living in other states who seek virtual care from an in-network provider will have the service paid at the virtual care benefit level.

**Virtual Care Options**
You can access virtual care through providers in your plan’s network. Go to medica.com/uofm, click on Find a Physician or Facility, select your plan and choose Virtual Care Providers. You options may include:
- Your clinic – check to see if virtual care is offered and learn how you can connect with your provider online or by e-visit
- OnCare is a virtual care provider for members in VantagePlus with Medica (featuring providers from Fairview, HealthEast, North Memorial, and many independent clinics including Boynton Health and University of Minnesota Physicians).
- Amwell ([amwell.com](http://amwell.com)) is a 24/7 online clinic available in every state. Amwell can be accessed from a mobile device - including smartphones and tablets - or a desktop computer for a video visit with a board-certified doctor who will review your history, answer questions, diagnose, treat, and prescribe medication (if needed).
  - Amwell also offers behavioral health care services including therapy and psychiatry. Eligible behavioral health services are covered as an office visit with a primary care copay.
- Virtuwell® ([virtuwell.com](http://virtuwell.com)) is a 24/7 online clinic available in select states for treatment of common medical conditions. You have an online visit with a certified nurse practitioner who will review your case and write a personalized treatment plan.
The University of Minnesota Wellbeing Program reflects the University’s goal to support all aspects of your wellbeing, including your physical, emotional, financial, and social health.

By participating in wellbeing activities, you will:

- Save money on your UPlan medical rates
- Earn points for activities you already do to stay healthy
- Have the chance to try out new wellbeing activities at little or no cost

**A. Confidential Program through External Providers**

The Wellbeing Program is administered by an outside independent organization and all information and personal health data is confidential. RedBrick Health serves as the University’s administrator.

**B. Program year: October 1, 2017, to August 31, 2018**

The points you earn from healthy activities add up to real savings on your 2019 UPlan medical rates—either $500 or $750 a year depending on whether you have a spouse who is covered under your UPlan medical plan.

<table>
<thead>
<tr>
<th>If your UPlan coverage is:</th>
<th>You need to earn at least:</th>
<th>To save this amount in 2019:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>500 points</td>
<td>$500</td>
</tr>
<tr>
<td>Employee and Children</td>
<td>500 points</td>
<td>$500</td>
</tr>
<tr>
<td>Employee and Spouse with or without Children</td>
<td>750 points (your spouse can earn up to $250 of these points)</td>
<td>$750</td>
</tr>
</tbody>
</table>

**C. New Employee Eligibility**

The date your benefits are effective and when you enroll in benefits determine how you qualify for an annual rate reduction.

- If your UPlan medical plan benefits are effective between June 1 and September 1, 2018, you can reduce your contribution for 2019 when you take the RedBrick Compass® Health Assessment by August 31, 2018, to receive the full incentive of $500 or $750.

- If your UPlan medical plan benefits are effective and/or you enroll on September 1, 2018, or later, you may begin to earn wellbeing points for 2020 starting on October 1, 2018.

**D. Getting started: Register and stay connected**

The University has a partner to help deliver the 2017-2018 Wellbeing Program: RedBrick Health. You have access to programs offered by the University and to RedBrick’s engaging online experience, which includes a wide variety of activities to help you earn points and meet your personal wellbeing goals.

While you can participate in the Wellbeing Program in any way you choose, the steps below are a common pathway that works well for many people. You will be able to log in to the RedBrick portal about seven to ten business days after your medical plan benefits become effective.

- Visit [UMN.RedBrickHealth.com](http://UMN.RedBrickHealth.com) to register your online account and have complete access to the Wellbeing Program. Or, you can get started over the phone by calling 844-724-8636.
- Complete the RedBrick Compass® Health Assessment—a short online questionnaire about your health—to find your strengths and see where you can improve.
- Take 15 minutes to review your Compass Health Assessment and/or health screening results over the phone with a RedBrick coach. The coach will help connect you to appropriate programs that best fit your goals, needs, and desires.
- Participate in a biometric health screening to get a better picture of your health.
- Search Redbrick Journeys with more than 65 different topics for self-paced virtual coaching.
- Check other programs including University fitness classes, mindfulness classes, cooking classes, the Fit Choices program, and the bike commuter programs.
### 2017-2018 Wellbeing Program Point Structure

<table>
<thead>
<tr>
<th>Category</th>
<th>Program</th>
<th>Points (500/750)*</th>
<th>Campuses Offered: Twin Cities (TC), Crookston (C), Duluth (D), Morris (M), Rochester (R)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Assessments</strong></td>
<td>RedBrick Compass® health assessment</td>
<td>100</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Next-Steps Consult™</td>
<td>50</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Biometric Health Screening</td>
<td>150</td>
<td>All</td>
</tr>
<tr>
<td><strong>Wellbeing My Way</strong></td>
<td>Annual Flu Shot Pledge</td>
<td>25</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Non-Tobacco User Pledge</td>
<td>25</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>RedBrick Track® (1 point per day)</td>
<td>75 maximum</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Self-Reported Volunteer Pledge</td>
<td>25</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Advance Care Directive (Honoring Choices) Pledge</td>
<td>25</td>
<td>All</td>
</tr>
<tr>
<td><strong>Be Active</strong></td>
<td>Bike Commuter (including Nice Ride) (50 rides / 100 rides per program year)</td>
<td>100/150</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Fit Choices Gym Reimbursement (8x per month /12x per month for 6 months)</td>
<td>100/150</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>RedBrick Rally (Challenges: 1-2 per year)</td>
<td>75/150 maximum</td>
<td>All</td>
</tr>
<tr>
<td><strong>Manage Your Health</strong></td>
<td>Weight Watchers On Campus** (14 sessions in 4 months, 2 series maximum)</td>
<td>200/400 maximum</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Healthy Pregnancy (3 phone coaching sessions)</td>
<td>125</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>RedBrick Journeys® (4-6 weeks avg each session; 6 Journeys maximum)</td>
<td>50 each/300 maximum</td>
<td>All</td>
</tr>
<tr>
<td><strong>Coaching and Support</strong></td>
<td>RedBrick Health Coaching (4 phone sessions)</td>
<td>250</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Face-to-Face Health Coaching (4 sessions ) - Incl. Stress Mgmt Coaching</td>
<td>250</td>
<td>TC, D, M</td>
</tr>
<tr>
<td></td>
<td>Group Coaching (7 sessions)</td>
<td>250</td>
<td>TC, D, M</td>
</tr>
<tr>
<td></td>
<td>Medication Therapy Management (3 sessions)</td>
<td>150</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Specialty Therapy Management (4 sessions)</td>
<td>150</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Four Cornerstones of Financial Literacy (4 of 4 sessions)</td>
<td>150</td>
<td>TC, D, M</td>
</tr>
<tr>
<td><strong>University Wellbeing Classes</strong></td>
<td>Group Strength Express** (13 of 16 classes, up to 3 sessions per year)</td>
<td>150/450 maximum</td>
<td>TC, D, M</td>
</tr>
<tr>
<td></td>
<td>Heart Rate Express** (13 of 16 classes, up to 3 sessions per year)</td>
<td></td>
<td>TC, M</td>
</tr>
<tr>
<td></td>
<td>Kettlebell Express** (13 of 16 classes, up to 3 sessions per year)</td>
<td></td>
<td>TC, M</td>
</tr>
<tr>
<td></td>
<td>Yoga 101** (13 of 16 classes, up to 3 sessions per year)</td>
<td></td>
<td>TC, D, M</td>
</tr>
<tr>
<td></td>
<td>Cross Training Express** (13 of 16 classes, up to 3 sessions per year)</td>
<td></td>
<td>TC, M</td>
</tr>
<tr>
<td></td>
<td>AquaFit** (13 of 16 classes, up to 3 sessions per year)</td>
<td></td>
<td>M</td>
</tr>
<tr>
<td></td>
<td>Mindfulness at Work** (5 of 6 online sessions)</td>
<td>150</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Mindfulness-Based Stress Reduction** (7 of 8 sessions)</td>
<td>150</td>
<td>TC</td>
</tr>
<tr>
<td></td>
<td>Cooking for Wellness - The Basics** (6 of 7 sessions)</td>
<td>150</td>
<td>TC, D, M</td>
</tr>
<tr>
<td></td>
<td>Cooking for Wellness - Getting Creative** (6 of 7 sessions)</td>
<td>150</td>
<td>TC</td>
</tr>
</tbody>
</table>

*Employee only and employee with children coverage can earn 500 points. Employee and spouse (with or without children) can earn 750 points. Spouses may earn 250 of the 750 points. **Programs eligible for 50% reimbursement up to $100. One class within each of the categories of fitness, mindfulness, or cooking classes is eligible for reimbursement per year. Two Weight Watchers series can be reimbursed per year.
XIV. Coordination of Benefits

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

A. Definitions
These definitions apply only to this section.

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

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

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

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

2. “This Plan” means the part of the Plan that provides health care benefits.

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

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

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

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

B. Order of Benefits Rules

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

   a) the other plan has rules coordinating its benefits with this Plan’s benefits; and

   b) the other plan’s rules and this Plan’s rules require this Plan to be primary.

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

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

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

i) the plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year; but

ii) if both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time.

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

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

i) first, the plan of the parent with custody of the child;

ii) then, the plan that covers the spouse of the parent with custody of the child;

iii) finally, the plan that covers the parent not having custody of the child.

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

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

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

C. Effect on Benefits of This Plan

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

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

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

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

D. Right to Receive and Release Needed Information

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

E. Facility of Payment

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

F. Right of Recovery

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

1. The persons it paid or for whom it has paid
2. Insurance companies
3. Other organizations

The amount paid includes the reasonable cash value of any benefits provided in the form of services.
If it is determined that your services will not be covered under the Plan, or are only partially covered, due to an eligibility, enrollment, or other administrative issue, you are entitled to file a request for review of that determination. You must follow the procedures listed below.

A. Employee Benefits Service Center Coverage Review Process for Eligibility, Enrollment, or Other Administrative Issues
If you are disputing a determination concerning an eligibility, enrollment, or other administrative issue, you may contact the University’s Benefits Service Center directly by telephone at 612-624-8647 or 800-756-2363, by fax at 612-626-0808, by email at benefits@umn.edu, or by mail to Employee Benefits, University of Minnesota, 200 Donhowe Building, 319 15th Avenue SE, Minneapolis, MN 55455-0103. You must contact the Employee Benefits Service Center within 90 days of the date that the eligibility, enrollment, or other administrative issue first became apparent.

The Benefits Service Center 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 Benefits Service Center as soon as possible, but not later than 30 days following the University’s receipt of your request for review.

B. Employee Benefits Committee Review of Coverage Denials
If you do not agree with the response from the University of Minnesota Employee Benefits Service Center concerning an eligibility, enrollment, or other administrative issue, you may request a review by the Employee Benefits Review Committee.

Your request must be in writing and be received by fax at 612-626-0808, by email at benefits@umn.edu, or by mail at Employee Benefits, University of Minnesota, 200 Donhowe Building, 319 15th Avenue SE, Minneapolis, MN, 55455-0103, within 60 days of the denial of response from the University of Minnesota Employee Benefits Service Center. A written decision will be mailed to you from the Employee Benefits Review Committee within 30 days of the University’s receipt of your request for review.

C. Employee Benefits Director Final Review
If you wish to pursue a denial from the Employee Benefits Review committee, you must submit a final appeal to the Employee Benefits Director within 60 days of receiving a denial of coverage from the Employee Benefits Review Committee. You must submit your written request for appeal to Employee Benefits, University of Minnesota, 200 Donhowe Building, 319 15th Avenue SE, Minneapolis, MN, 55455-0103. The Employee Benefits Director will render a final written decision regarding your appeal within 45 days of your written request.
If your claim for benefit payments under the Plan is wholly or partially denied, if the care that you need requires a prior authorization or other claim review process that has not been approved, or if you have an urgent need for care that has been wholly or partially denied, you are entitled to file a request for review.

You must follow the procedures for review of disputed claims that are summarized below.

A. Medical or Pharmacy Claims Administrator Review and Appeal Process

Call or write the Medical or Pharmacy Claims Administrator Member Services Department using the appropriate phone number listed on your medical ID card. The representative will 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 reasons you believe you are entitled to benefits and supporting documentation, must be submitted to the Claims Administrator within 180 days.

a) The Claims Administrator will review your request and you will receive a written notification of the decision within 30 calendar days after the Claims Administrator receives your written request for review.

b) If waiting the standard 30-day turnaround time might jeopardize your life, health, or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting, you or your attending provider may request an expedited, 72-hour appeal review. In such cases, you may also have the right to request an external review while your appeal review is being conducted.

The Claims Administrator’s written notice will include the following information:

- the reason for approval or denial;
- the Plan provisions on which the decision is based;
- any additional material or information needed; and
- the procedure for requesting an independent external review of your denied claim or future claim.

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 Claims Administrator will refer your request to the University of Minnesota Employee Benefits Service Center.

B. Independent Review Organization Review and Appeal Process

If you wish to appeal a claim denial from the Medical or Pharmacy Claims Administrator, you must submit a written appeal for an external review within four months of receiving the Claims Administrator’s denial. Your request for an external review should be submitted to the Claims Administrator at the address shown in the introduction to the Summary of Benefits. Your appeal will then be assigned to an accredited Independent Review Organization (IRO) to conduct an external review.

The IRO will provide a notice to you of the acceptance for review and the deadline for submitting any additional information. The external review decision will be provided by the IRO to you and the plan administrator within 45 days of receipt of request for review. If waiting the standard 45-day turnaround time might jeopardize your life, health, or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting, you or your attending provider may request an expedited, 72-hour appeal review.

Decisions of the IRO related to the medical necessity of the claim will be considered final.
XVI. Disputing a Preliminary Claim Review or Claim Payment Denial

C. Optional Employee Benefits Review Committee Appeal Process

In certain limited circumstances, if your claim for benefits under the plan is wholly or partially denied at the level of the Independent Review Organization (IRO), you may request a review of your claim by the Employee Benefits Review Committee. Reviews by the Employee Benefits Review Committee are limited to issues related to the procedures and processes used by the Claims Administrator in making claim decisions and not to the medical necessity of the claim where the final decision is made by the IRO.

Your request must be in writing and received by Employee Benefits, University of Minnesota, 200 Donhowe Building, 319 15th Avenue SE, Minneapolis, MN, 55455-0103, within 60 days of the denial of your appeal by the IRO. A final written decision for issues related to claim processes and procedures will be mailed to you by Employee Benefits within 30 days of the receipt of your request for review by the Employee Benefits Review Committee.

XVII. Plan Amendments

The University of Minnesota Employee Benefits Office will interpret the Plan and its Summary of Benefits as needed to advise Claims Administrators on their administration of the Plan. The University of Minnesota may amend the Plan. Plan Amendments will be communicated to Members during Open Enrollment.
If the Claims Administrator pays medical benefits for medical or dental expenses you incur as a result of any act of a third party for which the third party is or may be liable, and you later obtain full recovery, you are obligated to reimburse the Claims Administrator for the benefits paid in accord with Minnesota statutes 62A.095 and 62A.096, the laws regulated to subrogation rights. “You” means you and your covered spouse and dependents for purposes of this Section.

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

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

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

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

Notwithstanding any other law to the contrary, the statute of limitations applicable to the Claims Administrator’s rights for reimbursement or subrogation does not commence to run until the notice has been given.
XIX. Notice of Privacy Practices

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

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

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

This notice of privacy practices (“Notice”) applies to the health plans sponsored by the University of Minnesota (“Group Health Plan”). The Group Health Plan includes the following components of UPlan benefits:

» UPlan Medical Plan, administered by Medica
» UPlan Pharmacy Program, administered by Prime Therapeutics and Fairview Specialty Pharmacy
» UPlan Medication Therapy Management, administered by the UPlan MTM Network and Network Pharmacies
» UPlan Dental Plans, administered by Delta Dental and HealthPartners
» Health Care Flexible Spending Accounts, administered by Discovery Benefits
» Global Medical Assistance Program, administered by UnitedHealthcare Global
» Wellbeing Program, administered by RedBrick Health, Medica, and the University of Minnesota
» University of Minnesota Employee Assistance Program, provided by the University of Minnesota and Sand Creek

B. Your Protected Health Information

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

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

The Group Health Plan may use and disclose your PHI information.

» 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 provide other administrative services.

» For Health Care Operations necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, the Group Health Plan might suggest a disease management or wellness program that could help improve your health, or we may analyze data to determine how to improve services. Although our claims 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.
XIX. Notice of Privacy Practices

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

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

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

» To Organizations Referred to as Business Associates that perform functions on our behalf or provide us with services, if the information is necessary for such functions or services. For example, we periodically retain an organization to audit our UPlan 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.
D. Your Rights Concerning your PHI

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

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

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

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

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

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

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

G. Contact Information
If you have questions or need further information, please contact:

1. University of Minnesota Privacy Office
   Mayo Mail Code 501
   420 Delaware Street SE
   Minneapolis, MN 55455

   612-624-7447
   privacy@umn.edu

Effective date of this notice: September 23, 2013
XX. Notice Regarding the University of Minnesota Wellness Program

The University of Minnesota Wellness Program is a voluntary wellness program available to all employees who participate in the UPlan Medical Program. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program you can choose to complete a Wellness Assessment which asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also choose to complete a biometric screening, which will include a blood test for cholesterol and blood glucose. You are not required to complete the Wellness Assessment or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program can qualify for an incentive of a $400 or $600 reduction in Medical Program rates (depending on the level of Medical Coverage that they have elected).

The incentive is available to employees who complete a number of wellness related activities which qualify them to earn 400 or 600 wellness points, and the resulting reduction in rates. Although you are not required to complete the Wellness Assessment or participate in the biometric screening, you may choose to do so to help earn your incentive.

Additional incentives of up to approximately $200 may be available for employees who participate in certain health-related group fitness, stress management, weight management, and cooking courses. If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Employee Benefits at 612-624-8647 or 1-800-736-2363, select option 1.

The information from your Wellness Assessment and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you coaching services through the wellness program, such as lifestyle coaching to help you reduce a health risk, or condition management coaching to help you manage a medical condition. You also are encouraged to share your results or concerns with your own medical provider.

A. Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the University of Minnesota may use aggregate information it collects to design a program based on identified health risks in the workplace, the Wellness Program will never disclose any of your personal information either publicly or to the University, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law.

Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.
XX. Notice Regarding the University of Minnesota Wellness Program

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive.

Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) a health coach, a registered nurse, or a medication therapy management pharmacist, in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separately from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision.

Appropriate precautions will be taken to avoid any data breach and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

B. Contact Information

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Employee Benefits at 612-624-8647 or 1-800-736-2363, select option 1.
XXI. COBRA Notice

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

Under the University of Minnesota UPlan, COBRA coverage applies to medical and dental benefits and the flexible spending account. Minnesota state law continuation applies to life insurance benefits.

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

This notice provides a summary of your COBRA continuation rights. For more information about your rights and obligations under the UPlan and under federal law, you should review the Eligibility section.

Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

It is important that you choose carefully between COBRA continuation coverage and other coverage options because once you’ve made your choice, it can be difficult or impossible to switch to another coverage option.

A. Continuation of Coverage

COBRA continuation coverage is a continuation of UPlan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the UPlan because of a qualifying event. Depending on the type of qualifying event, employees, spouses and dependent children may be qualified beneficiaries. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage.

1. If you are an employee, you will become a qualified beneficiary if you will lose coverage under the UPlan due to one of the following qualifying events:

   a) your hours of employment are reduced below a 50 to 74 percent time appointment; or

   b) your employment is terminated for any reason other than gross misconduct.

2. If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the UPlan because any of the following qualifying events:

   a) employee dies;

   b) employee’s hours of employment are reduced;

   c) employee’s employment ends for any reason other than his or her gross misconduct;

   d) employee retires at age 65 or over and enrolls in Medicare (Part A, Part B); or

   e) employee divorces.
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3. Your dependent children will become qualified beneficiaries if they will lose coverage under the UPlan because of any of the following qualifying events:

   a) employee dies;

   b) employee’s hours of employment are reduced;

   c) employee’s employment ends for any reason other than his or her gross misconduct;

   d) employee retires at age 65 or over and enrolls in Medicare (Part A, Part B); or

   e) dependent child is no longer eligible for coverage because he or she has reached age 26 or has otherwise lost eligibility for the program; or

   f) employee is divorced.

The UPlan will offer COBRA continuation coverage to qualified beneficiaries only after Employee Benefits has determined that a qualifying event has occurred such as the end of employment, reduction of hours of employment, death of the employee, or retirement of an employee age 65 or over and enrollment of same employee in Medicare (Part A, Part B, or both). Your coverage will terminate at the end of the month in which a qualifying event has occurred unless you elect COBRA continuation coverage. You have 60 days from the date of loss of coverage to elect COBRA continuation coverage.

Note: For other qualifying events – divorce or a dependent child losing eligibility for coverage – you must notify Employee Benefits within 30 days after the qualifying event occurs. You must either send a letter of notification to: Employee Benefits, 200 Donhowe Building, 319 15th Avenue SE, Minneapolis, MN 55455; or call the Employee Benefits Service Center at 612-624-8647 or 800-756-2363. Employee Benefits will send you the appropriate form to complete. This form must then be completed and sent to Employee Benefits at the address above, and postmarked within the 30-day time limitation. Your coverage will terminate at the end of the month in which the qualifying event occurs unless you elect COBRA continuation coverage. You have 60 days from the date of loss of coverage to elect COBRA continuation coverage.

Once Employee Benefits notifies the UPlan COBRA Administrator that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA, coverage will begin on the date the UPlan coverage would otherwise have been lost.

B. Qualifying Events Determine Length of Coverage

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

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

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

   If you or anyone in your family who is currently covered under the UPlan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months.
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You must make sure that Employee Benefits is notified of the Social Security Administration’s (SSA) determination within 60 days of the latest of:

a) the date of the SSA determination,

b) the date of the qualifying event,

c) the date of the loss of coverage, or

d) the date you are informed of your obligation and the procedure to provide this information, and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the UPlan COBRA Administrator. If you fail to notify Employee Benefits in writing and postmarked within the time limit, you will lose your right to extend coverage due to disability. Under this provision, you must also notify Employee Benefits within 30 days if the SSA determination is revoked.

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

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

3. Medicare Entitlement

If the qualifying event is your termination of employment or reduction of hours of employment, and you became entitled to Medicare benefits less than 18 months before your qualifying event, COBRA coverage under the Plan’s Medical and Dental components for qualified beneficiaries (other than you) who lose coverage as a result of your termination of employment or reduction of hours can last until up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if you became entitled to Medicare within 18 months before your termination or reduction of hours.

You must notify Employee Benefits in writing within 30 days if, after electing COBRA, you or a family member become entitled to Medicare (Part A, Part B, or both) or become covered under other group health plan coverage. You must follow the notice procedures specified in this notice.

In addition, if you were already entitled to Medicare before electing COBRA, you must notify Employee Benefits of the date of your Medicare entitlement.

C. End of COBRA Continuation Coverage

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

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

2. The premium for your continuation coverage is not paid in a timely fashion.
Note: You will have 45 days from the date you elect COBRA continuation coverage in which to make your first premium payment to the UPlan COBRA Administrator. After the first payment, there is a 30-day grace period for all future payments. For example: All regular COBRA continuation payments are due on the first day of the month. If your payment is due on January 1, your payment must be postmarked within 30 days or January 30. Payments made after the 30-day grace period will be returned to you and all coverage will be cancelled as of the end of the month in which the last regular payment was made.

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

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

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

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

E. Keep Your Plan Informed of Address Changes
In order to protect the rights of you and your family, you should keep Employee Benefits informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices sent by you to Employee Benefits or to the UPlan COBRA Administrator.

F. Questions About Billing
The UPlan COBRA Administrator is responsible for administering COBRA continuation coverage. If you have any questions about your billing, you may contact the appropriate UPlan COBRA Administrator directly.

1. UPlan COBRA Administrator — Medical, Dental and Life Insurance:
   For billing questions about medical or dental benefits or life insurance coverages, the UPlan COBRA Administrator is:
   121 Benefits
   730 2nd Ave S, Suite 400
   730 Building
   Minneapolis, MN 55402
   Phone: 612-887-4321, Option 2
   Toll Free: 1-800-300-1672

2. UPlan COBRA Administrator — Flexible Spending Account: For billing questions about the flexible spending account, contact:
   Employee Benefits Service Center
   612-624-8647 or 800-756-2363

G. Questions About Coverage
If you have questions about your COBRA coverage, you should call should call 612-624-8647 or 800-756-2363 to reach the Employee Benefits Service Center, or you may contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone numbers of the Regional and District EBSA Offices are available through the EBSA website at www.dol.gov/ebsa.
XXII. Important Notice from the UPlan Medical Program for Employees, Early Retirees, Disabled, and COBRA Participants and Dependents Concerning Your Prescription Drug Coverage and Medicare

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

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

This notice has information about your current prescription drug coverage with the University of Minnesota’s UPlan Medical Program for employees, early retirees, disabled, and COBRA participants (and dependents) and the prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium. The eight plans in the University of Minnesota Retiree Medical Program for Over 65 Retirees will automatically enroll you in the Medicare prescription drug benefit and will include coverage that is at least as good as the Medicare prescription drug benefit.

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

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

Because your existing UPlan Employee Medical coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in the Medicare prescription drug program.

If you decide to enroll in a Medicare prescription drug plan and drop your UPlan Employee Medical Program prescription drug coverage for retirees over age 65, be aware that you cannot get this coverage back.

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

You should also know that if you drop or lose your coverage with your UPlan Employee Medical Program and don’t enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.
If you go 63 days or longer without prescription drug coverage that’s at least as good as Medicare’s prescription drug coverage, your monthly premium will go up at least one percent per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19 percent higher than what many other people pay. You’ll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two month Special Enrollment Period to join a Medicare drug plan.

Call 612-624-8647 or 800-756-2363 to reach the University of Minnesota Employee Benefits Service Center.

NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through the UPlan Employee Medical Program changes. You also may request a copy.

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

For more information about Medicare prescription drug plans:

» Visit [www.medicare.gov](http://www.medicare.gov)

» Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help

» Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

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

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

Date: December 2017
Sender: University of Minnesota Employee Benefits Department

Contact: Employee Benefits Service Center
Address: 319 15th Avenue SE, Minneapolis, MN 55455-0103
Phone Number: 612-624-8647 or 1-800-756-2363
XXIII. Children’s Health Insurance Program Notice

Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply.

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

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

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

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

Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

If you live in another state, contact the Employee Benefits Service Center to obtain more information about the availability of CHIP coverage.

XXIV. HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Call the Employee Benefits Service Center to request special enrollment or obtain more information about your coverage options.
This Summary of Benefits booklet provides a complete description of your medical benefits, their limitations, and exclusions.

If there are any differences between the Guide for UPlan Benefits Enrollment and this Summary, the Summary of Benefits will govern.

The University of Minnesota shall provide equal access to and opportunity in its programs, facilities, and employment without regard to race, color, creed, religion, national origin, gender, age, marital status, disability, public assistance status, veteran status, sexual orientation, gender identity, or gender expression.

Inquiries regarding compliance may be directed to the Director, Office of Equal Opportunity and Affirmative Action, University of Minnesota, 274 McNamara Alumni Center, 200 Oak Street S.E., Minneapolis, MN 55455, (612) 624-9547, eoaa@umn.edu. Website at www.eoaa.umn.edu.

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