



SUMMARY OF BENEFITS MEDICAL CARE COVERAGE

Effective January 1, 2023

Be prepared for a medical emergency before the need arises by knowing your clinic's procedure for care 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.

REDPOINT

This is a 24/7 Medical Assistance Program for worldwide emergency medical assistance and other travel assistance services when you are 100 or more miles away from home. It also includes assistance, evacuation, and repatriation coverage during a political or natural disaster emergency, if you need help to protect your own safety and potentially get out of the area.

For questions or emergency services, call 1-855-516-5433 (toll-free in the U.S. or Canada) or 1-415-484-4677 (international).

BENEFIT QUESTIONS

You can reach the Office of Human Resources (OHR) Contact 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. See page 107 for details.

Introduction

This Summary of Benefits describes the coverage you have for medical benefits under the University of Minnesota Medical Plan (the Plan) in Plan Year 2023. 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, including treatment of illness and injury through office visits, surgical procedures, hospitalizations, lab tests, programs for behavioral and mental health and substance use disorders, 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 Wellbeing 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 Virgin Pulse, the Wellbeing Program administrator.

At Open Enrollment each year, you can select the medical plan option you want to use for the year. Your cost varies depending on which medical plan 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 more information about your medical, pharmacy, and Wellbeing Program benefits, email or call the OHR Contact 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: Call 711
Website: www.medica.com/uofm

WELLBEING PROGRAM ADMINISTRATOR

Virgin Pulse
510 S Marquette Ave #500
Minneapolis, MN 55402

Phone: 1-833-996-1870
Access through z.umn.edu/WellbeingPgrm 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

Fairview Specialty Pharmacy
711 Kasota Avenue
Minneapolis, MN 55414

Phone: 612-672-5289
Toll Free: 1-877-509-5115
Website: www.fairviewspecialtyrx.org/uplan

OHR CONTACT CENTER

ohr@umn.edu
612-624-8647
800-756-2363

Specific Information About the Plan

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

Address of the Plan: University of Minnesota
Total Rewards
100 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 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: Virgin Pulse
510 S Marquette Ave #500
Minneapolis, MN 55402

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Medical: Plan Comparison

IN-NETWORK SERVICES

Health Care Services	Base Plan Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Preventive Care ¹	100% coverage	100% coverage	100% coverage	100% coverage ²
Eye and Hearing Exam (routine)	100% coverage	100% coverage	100% coverage	100% coverage
Physician ³	\$25 Primary/ \$35 Specialty copay	\$20 Primary/ \$30 Specialty copay	\$40 Primary/ \$50 Specialty copay	90% coverage after deductible
All Walk-in/ Convenience Clinics and Virtual Care ⁴	\$15 copay	\$15 copay	\$20 copay	90% coverage after deductible
Outpatient MRI and CT Scan	\$50 copay	\$40 copay	\$50 copay	90% coverage after deductible
Urgent Care: In-Network and Out-of-Network	\$25 copay	\$20 copay	\$40 copay	90% coverage after deductible
Emergency Care: In-Network and Out-of-Network	\$100 copay, waived if admitted	\$100 copay, waived if admitted	\$100 copay, waived if admitted	90% coverage after deductible
Outpatient Mental Health/ Substance Use ⁵	\$25 copay	\$20 copay	\$40 copay	90% coverage after deductible
Chiropractic Care	\$25 copay	\$20 copay	\$40 copay	90% coverage after deductible
Physical, Speech, and Occupational Therapy	\$25 copay	\$20 copay	\$40 copay	90% coverage after deductible
Home Health Care	\$25 copay	\$20 copay	\$40 copay	90% coverage after deductible

¹ Preventive care includes routine physical, hearing and eye exams; well child care; prenatal care; immunizations; and allergy injections.

² HSA guidelines do not view allergy injections as preventive; therefore, the deductible and coinsurance apply to this service.

³ Primary Care includes Family Medicine, Internal Medicine, Obstetrics/Gynecology, and Pediatrics.

⁴ Gopher Quick Clinic in the Twin Cities and other walk-in/convenience care clinics; also applies to virtual care.

⁵ Outpatient Mental Health/Substance Use virtual care services will apply the office visit benefit.

Medical: Plan Comparison

IN-NETWORK AND OUT-OF-NETWORK SERVICES

Deductibles and Services	Base Plan Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
In-Network Deductible¹	\$100 per person/ \$200 per family	\$100 per person/ \$200 per family	\$200 per person/ \$400 per family	Total in-network and out-of-network: Employee only: \$1,500 Family: \$3,000
Out-of-Network Deductible	\$600 per person/ \$1,200 per family	\$600 per person/ \$1,200 per family	\$600 per person/ \$1,200 per family	
Annual Out-of-Pocket Maximum*	\$2,500 per person/ \$4,000 per family	\$2,500 per person/ \$4,000 per family	\$2,500 per person/ \$4,000 per family	\$3,000 employee only/ \$6,000 per family (Note: Out-of-pocket maximums include the deductible)
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Lab/X-Ray	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% coverage after deductible
Outpatient Surgery	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% coverage after deductible
In-Network Hospital (General and Mental Health/ Substance Use Care)	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% coverage after deductible
Ground and Air Ambulance to Nearest Facility	80% coverage	80% coverage	80% coverage	90% coverage after deductible
Prosthetics, Durable Medical Equipment	80% coverage, including hearing aids	80% coverage, including hearing aids	80% coverage, including hearing aids	90% coverage after deductible, including hearing aids
Out-of-Network Care²	70% coinsurance after deductible is met	70% coinsurance after deductible is met	70% coinsurance after deductible is met	70% coinsurance after deductible is met

¹In-network deductible applies to expenses without a copay, primarily in- and out-patient hospital, and lab/x-ray.

²**If you visit an out-of-network provider, Medica discounts do not apply.** That means your out-of-pocket costs can be much higher, potentially thousands of dollars. Plus, Medica usually pays out-of-network providers less than the amount they bill. When this happens, you're responsible for paying the provider the balance. Federal law provides protections from balance billing in certain circumstances when you receive services from out-of-network providers. Please refer to **5.N. Out-of-Network Care** for more information.

*If you go out of network, you could end up paying more than the out-of-pocket maximum, because certain amounts you pay don't count toward the maximum. Plus, even after you've met your out-of-pocket maximum, you'll continue to pay the difference between what the provider bills and what Medica pays.

Medical: Plan Comparison

PRESCRIPTION DRUGS

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

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

Prescription Drug Categories	Base Plan Medica Elect/ Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Certain Preventive Medications Specified in the Affordable Care Act and Contraceptives in the Generic Plus Category	\$0 copay	\$0 copay	\$0 copay	100%
Generic Plus (Tier 1) Drugs (includes covered generic drugs and some low-cost brand drugs if there is no covered generic drug in a given therapeutic class.)	\$10 copay	\$10 copay	\$10 copay	Prescriptions are covered in the HSA and at 90% in medical plan after deductible
Formulary Brand Name (Tier 2) Drugs (includes other covered formulary brand drugs)	\$30 copay	\$30 copay	\$30 copay	Prescriptions are covered in the HSA and at 90% in medical plan after deductible
Non-formulary (Tier 3) Drugs (includes covered brand drugs not listed on formulary)	\$75 copay	\$75 copay	\$75 copay	Prescriptions are covered in the HSA and at 90% in medical plan after deductible
Purchase of Brand Drug When Chemically Equivalent Generic is Available	Pay the generic copay and difference in cost¹ between the brand drug and the generic drug	Pay the generic copay and difference in cost¹ between the brand drug and the generic drug	Pay the generic copay and difference in cost¹ between the brand drug and the generic drug	Prescriptions are covered in the HSA and at 90% in medical plan after deductible ²
Drugs Purchased by Mail Order	3-month supply available for two copays	3-month supply available for two copays	3-month supply available for two copays	90-day supply available at discount
Annual Out-of-Pocket Maximum (Rx only)	\$750 per person/ \$1,500 per family	\$750 per person/ \$1,500 per family	\$750 per person/ \$1,500 per family	No separate out-of-pocket maximum for prescriptions

¹ The difference in cost does not apply toward the annual out-of-pocket maximum.

² When in the coinsurance level, pay 10% coinsurance based on generic price in addition to difference in cost between the brand drug and the generic drug.

Medical: Plan Comparison

OTHER COVERAGE AND MAXIMUMS

Other Coverage and Maximums	Base Plan Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Travel Benefit: In-Network Coverage	For students and other travelers if services are provided by United Healthcare Options PPO providers	For students and other travelers if services are provided by United Healthcare Options PPO providers	For out-of-area residents, students and other travelers if services are provided by United Healthcare Options PPO providers	For out-of-area residents, students and other travelers if services are provided by United Healthcare Options PPO providers
National Coverage	Available through emergency or out-of-network benefit only	Available through emergency or out-of-network benefit only	Available in-network through United Healthcare Options PPO network	Available in-network through United Healthcare Options PPO network

*If you go out of network, you could end up paying more than the out-of-pocket maximum, because certain amounts you pay don't count toward the maximum. Plus, even after you've met your out-of-pocket maximum, you'll continue to pay the difference between what the provider bills and what Medica pays.

Annual HSA Contributions	University Contribution	Employee Maximum Contribution	Total Annual Contribution
Employee-only amount	\$750	\$3,100	\$3,850
Family coverage amount (either tier)	\$1,500	\$6,250	\$7,750
Catch-up amount - Age 55 or over		\$1,000	2023 max + \$1,000 catch-up

1. Introduction to Your Medical and Pharmacy Coverage

The University of Minnesota (“Sponsor”), which serves as sponsor of the plan, has established the University Medical Plan (“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, 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 interpret 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

1. Introduction to Your Medical and Pharmacy Coverage

C. Summary of Benefits

This Summary of Benefits is your description of the Plan. It describes the Plan's benefits and limitations for your medical coverage. Please read this entire summary carefully. Many of its provisions are interrelated, and reading just one or two provisions may give you incomplete information about 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 is available to view and download on the Employee Benefits website at <https://z.umn.edu/medicalplans>.

D. Identification (ID) Cards

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 Member Service Department of any errors.

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

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 Member Service Department if the clinic information is incorrect. Contact the University of Minnesota OHR Contact Center 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 Medications. 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 get 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 site.

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.

1. 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 **19. 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 plan's care coordinators will work with your medical providers when you are receiving treatment for one of the following conditions or situations:

- An acute condition
- A life-threatening mental or physical illness
- Pregnancy once confirmed by a physician
- 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
- A disabling or chronic condition that is in an acute phase
- 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
- 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 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 help you complete 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. Your plan membership number must be on the claim. The Plan may request that more information be submitted 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
P.O. Box 30990
Salt Lake City, UT 84130

Prime Therapeutics LLC
P.O. Box 14527
Lexington, KY 40512-4430

2. 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 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 Plan 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 pages 16-17 for Tax Favored and Non-Tax Favored Treatment of Dependent Coverage for further explanation.

2. 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 available at: <https://shb.umn.edu/health-plans/rfi>

2. Coverage Eligibility and Enrollment

Definition of eligible dependents

The chart below specifies the criteria for coverage along with whether the dependent is considered qualified for favorable tax treatment under the Plan.

Relationship to Employee	Criteria for Coverage	Is Dependent Qualified for Tax-Favored Treatment ⁽¹⁾
Spouse	Must be legally married	Qualified
Dependent Child	<p>Dependent child—birth through age 25 (up to the 26th birthday)</p> <p>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.</p> <p>Note: The spouse of your eligible married dependent child is not eligible for coverage.</p>	Qualified
	<p>Disabled child—age 26 or above (no maximum) if physically or mentally disabled and either:</p> <ul style="list-style-type: none"> • 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 	Qualified
Dependent Grandchild	<p>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.</p>	Qualified
	<p>Additional grandchildren eligibility—An unmarried grandchild is also eligible under the Plan for coverage if 1) the grandchild is dependent on 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 on 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.</p> <p>Newborns—Your newborn infant grandchild is eligible under the Plan for coverage if the grandchild is financially dependent on you and lives with you continuously from birth. Coverage for the grandchild may end if the grandchild does not continue to live with you continuously, if the grandchild does not remain financially dependent on you, or when the grandchild reaches age 26.</p>	Usually non-qualified

¹ "Tax-Favored Treatment" refers to how dependent coverage is treated for tax purposes.

2. Coverage Eligibility and Enrollment

2. Tax-Favored and Non-Tax-Favored Treatment of Dependent Coverage

- a) If the column on the right is marked “Qualified” for a dependent category, it means you will pay pre-tax contributions for yourself and any dependents. It also means 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 column on the right is marked “Non-qualified” for a dependent category, it means 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 a qualified or non-qualified dependent for purposes of determining whether coverage is tax favored under the Plan, and to enroll your dependent correctly. One general guideline is that if the child is considered your dependent for tax purposes, they are 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 taxing 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.

2. 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 on 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 on 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 on you and lives with you continuously from birth. Coverage for the grandchild may end if the grandchild does not continue to live with you continuously, if the grandchild does not remain financially dependent on you, or when the grandchild reaches age 26.

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.

5. Coverage of Disabled Children of Any Age

- a) Your dependent child of any age is eligible for coverage and tax-favored status if they are incapable of self-sustaining employment by reason of mental retardation, mental illness, mental disorder, or physical disability, and is chiefly dependent on you for 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 University 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 before age 26, then wish to cover the child again, coverage must be added before the child turns 26, and their disabled status recertified by the Claims Administrator.
 - ii) Once your disabled child has reached 26, the child must be continuously covered under the Plan 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

2. Coverage Eligibility and Enrollment

ii) The Plan 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 they continue to be disabled and dependent, unless coverage otherwise terminates under the Plan.

A dependent child who is considered to be disabled by the Plan 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 because of a medical child support order are eligible, as required by federal and state law to ensure 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

Other than when you are first eligible, to make changes in your medical, dental, optional life coverage, or flexible spending accounts 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 the current plan's service area and the current plan is not available

Call the OHR Contact Center if you have more specific questions about changes in your coverage.

9. Dependent Eligibility Verification

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

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

Please respond to the verification request from the Office of Human Resources promptly to ensure coverage for your dependents.

2. 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 date you return 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 start 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 before an employee's coverage.

C. Pre-existing Conditions

The Plan does not have a pre-existing condition clause. This means 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 your hire date 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 able 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 (for example, 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 coverage begins. You may elect any of the University medical plan options, other than Medica Health Savings Account (HSA), for this waiting period 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 OHR Contact 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.

2. Coverage Eligibility and Enrollment

F. Open Enrollment

During the University of Minnesota 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 to your University 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 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
- 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 Plan.
4. When your dependent child up to age 26 newly 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 Medical Plan 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 Medical Plan 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 or home.
3. Any Claims Administrator participating in the University of Minnesota Medical Plan terminates or is terminated from participation in the Plan.
4. The University of Minnesota approves a request from an employee due to an administrative error that occurs during Open 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 University medical plan in the **60 days** immediately preceding the effective date of retirement.

2. Coverage Eligibility and Enrollment

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 marriage for coverage to become effective on the marriage date.

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: 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 Plan 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/Children's Health Insurance Program (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 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. Affordable Care Act (ACA) Special Enrollment

If you are ineligible to participate in the medical plan because you initially work fewer than 30 hours per week or your weekly hours of service vary, you may become eligible to participate in University Medical coverage for one year, under guidelines of the ACA, if you have worked 30 hours or more per week on average during the past year. Eligibility for this coverage is determined once a year (using the same standard measurement period) for all employees who have worked over a year. Eligibility for new employees who have not yet completed one year of service is determined using an initial measurement period that is specific to each new employee. Each employee will be notified in writing if they become 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.

2. 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 so your current plan is not available
- You retire
- Your work appointment decreases to fewer than 30 hours per week
- You and/or your dependents 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. If you do not waive coverage within 30 days you will not be 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 up to age 26 newly meets eligibility criteria as stated in the chart in **A. Eligibility**.

If you decide to elect coverage as a result of a status change event, you must enroll **within 30 days** of the qualifying event. If you do not enroll within 30 days you will not be able to make changes until the following Open Enrollment. You may also be eligible to elect medical coverage after waiving coverage if you experience a Special Enrollment event listed in **J. HIPAA Special Enrollment Rights Changes**.

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)
 - f) During an Open Enrollment

If you experience one of these status changes, you are obligated to contact the OHR Contact Center within 30 days.

2. Coverage Eligibility and Enrollment

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 dependent knowingly makes fraudulent misstatements about 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 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 the Office of Human Resources promptly of loss of eligibility for your dependents
- 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

2. 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 Plan, 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 in the 24 months after your coverage ends.

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 to continue coverage. In all cases, continuation ends if the Plan ends or required charges are not paid when due.

The following section generally describes continuation coverage under this Plan. Also refer to **21. COBRA Notice** for more information.

2. Coverage Eligibility and Enrollment

Qualifying Event	Who May Continue	Maximum Continuation Period
Employment ends, certain leaves of absence, layoff, or reduction in hours (except gross misconduct dismissal)	Employees and dependents	Earlier of: <ul style="list-style-type: none"> • Enrollment date in other group coverage, or • 18 months
Divorce	Former spouse and any dependent children who lose coverage	Earlier of: <ul style="list-style-type: none"> • 36 months from the date of divorce, • Enrollment in other group coverage, or • Date coverage would otherwise end
Death of employee	Surviving spouse and dependent children	Earlier of: <ul style="list-style-type: none"> • Enrollment date in other group coverage, or • Date coverage would otherwise end
Dependent child loses eligibility	Dependent child	Earlier of: <ul style="list-style-type: none"> • 36 months from the date of losing eligibility, • Enrollment in other group coverage, or • Date coverage would otherwise end
Employee retires at age 65 or over and enrolls in Medicare Part A, Part B, or both	Employee and dependents	Earliest of: <ul style="list-style-type: none"> • 36 months from date of enrollment in Medicare, or • Enrollment in other group coverage, or • Date coverage would otherwise end
Surviving dependent of retiree on lifetime continuation due to bankruptcy of Employer	Surviving spouse and dependents	• 36 months following retiree's death
Total disability ¹	Employee and dependents	Earlier of: <ul style="list-style-type: none"> • Date total disability ends, or • Date coverage would otherwise end
Total disability of dependent ²	Dependent	Earliest of: <ul style="list-style-type: none"> • 18 months, or • 29 months after the employee leaves employment, or • Date total disability ends, or • Date of enrollment in Medicare, or • Date coverage would otherwise end

2. Coverage Eligibility and Enrollment

¹ Total disability means the employee's inability to perform the duties of the employee's regular occupation or employment within the first two years of the disability. After the first two 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 before January 1, 1992, total disability means the employee's inability to perform the duties of the employee's regular occupation or employment from the date of disability.

² 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. To qualify, the disabled dependent must meet these 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 the Office of Human Resources 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. If you do not choose continuation within the required time, you or your covered dependents will not be able 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.

Charges for continuation are the Plan group rate plus a 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 to continue coverage. Continuation charges must be paid in the same manner as for the initial qualifying event.

A qualified beneficiary is any person 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.

2. 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 get 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 on either work location or where they live. However, if you select an Accountable Care Organization (ACO), you and your dependents must live or work in one of the counties in the ACO's service area. You may be able to choose other options, but they have limited provider availability.

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

S. Employees Whose Permanent Work Location Is Required to Be Outside of Minnesota

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.

The Office of Human Resources must have notification from the employee's department to verify that the employee is required to work out of state for the University.

T. Employees Whose Children Live Out-of-Area With an Ex-Spouse

Children living out of the service area with an ex-spouse may receive services from any licensed provider in the area in which they live 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 the OHR Contact Center to complete a form to designate this special coverage. If the ex-spouse is covered by the same Plan option, they would have out-of-area benefits consistent with the employee's medical plan and would not be eligible for this additional benefit.

U. Retirement

An employee covered by the Plan 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 Plan may maintain health coverage with the University.

Employees retiring under age 65 make a selection from the Plan options, while retirees over age 65 can elect a University of Minnesota over-65 retiree medical plan that incorporates Medicare benefits. Individuals on a University separation program, meeting the above criteria, are eligible to continue in the Plan 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, voluntarily or involuntarily, the retiree and their dependents may not rejoin the University of Minnesota Medical Plan.

2. Coverage Eligibility and Enrollment

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 University retiree group. Medicare will then become primary.

V. Long-Term Disability

An employee covered by the Plan 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 before transferring to the over-65 retiree/disability group at the carrier. Medicare will then become primary.

3. 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

You can get the most up-to-date participating provider information on Medica's website at www.medica.com/uofm. If you need more information, call Medica Member Service at 952-992-1814 or 1-877-252-5558 or register at medica.com/signin to get personalized information.

3. Changing Clinics

During the year, you can change your clinic by calling Medica Member 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. When you go out-of-network, you could end up paying more than the out-of-pocket maximum because certain amounts you pay don't count toward the maximum. For example, even after you've met the out-of-pocket maximum, you'll continue to pay the difference between what the provider bills and what Medica pays. In certain circumstances, out-of-network services are required to be covered as if they were in-network services. Please refer to **5.N. Out-of-Network Care** for more information.

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.

3. Plan Descriptions

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

2. How to Access a Provider Directory

You can get the most up-to-date participating provider information on Medica's website at www.medica.com/uofm. If you need more information, call Medica Member Service at 952-992-1814 or 1-877-252-5558 or register at medica.com/signin 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 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.

When you go out-of-network, you could end up paying more than the out-of-pocket maximum because certain amounts you pay don't count toward the maximum. For example, even after you've met the out-of-pocket maximum, you'll continue to pay the difference between what the provider bills and what Medica pays. In certain circumstances, out-of-network services are required to be covered as if they were in-network services. Please refer to **5.N. Out-of-Network Care** for more information.

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.

3. Plan Descriptions

C. Medica Accountable Care Organization (ACO) Plan

The 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 14-county metro area

- Your ACO options are:
 - VantagePlus with Medica (M Health Fairview, HealthEast, and North Memorial networks and Boynton Health and M Physicians)
 - Park Nicollet and HealthPartners Medical Group First with Medica
 - 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

You can get the most up-to-date participating provider information on Medica's website at www.medica.com/uofm. If you need more information, call Medica Member Service at 952-992-1814 or 1-877-252-5558 or register at medica.com/signin 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 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.

When you go out-of-network, you could end up paying more than the out-of-pocket maximum because certain amounts you pay don't count toward the maximum. For example, even after you've met the out-of-pocket maximum, you'll continue to pay the difference between what the provider bills and what Medica pays. In certain circumstances, out-of-network services are required to be covered as if they were in-network services. Please refer to **5.N. Out-of-Network Care** for more information.

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.

3. Plan Descriptions

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 19,500 physicians and over 270 hospitals. You also have national coverage access to more than 682,000 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

You can get the most up-to-date participating provider information on Medica's website at www.medica.com/uofm. If you need more information, call Medica Member Service at 952-992-1814 or 1-877-252-5558 or register at medica.com/signin 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 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. 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 Medica Member Service. In certain circumstances, out-of-network services are required to be covered as if they were in-network services. Please refer to **5.N. Out-of-Network Care** for more information.

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 Health Savings Account (HSA)

When you enroll in Medica HSA, you may seek medical care from any provider in the statewide Medica Choice network with over 19,500 physicians and more than 270 hospitals. When outside the service area, national coverage through United Healthcare Options PPO network gives you access to more than 682,000 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.

3. Plan Descriptions

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 midyear, 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 (FSA). 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

You can get the most up-to-date participating provider information on Medica's website at www.medica.com/uofm. If you need more information, call Medica Member Service at 952-992-1814 or 1-877-252-5558 or register at medica.com/signin 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 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. 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 Medica Member Service. In certain circumstances, out-of-network services are required to be covered as if they were in-network services. Please refer to **5.N. Out-of-Network Care** for more information.

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.

4. Pharmacy Benefits

Prime Therapeutics is the pharmacy benefits manager for the University of Minnesota 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 University medical plan 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 Medications 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 Plan Members with safe, effective, high-quality, and 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 University 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 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.

From January 15, 2022, through the end of the public health emergency related to COVID-19 as declared by the Secretary of Health and Human Services, OTC COVID-19 test kits are covered without a prescription, subject to the following rules.

Reimbursement is limited to \$12 per test (or the actual cost, if less) and no more than eight tests per 30 days per covered member in your household. For purposes of these limits, the plan counts each test separately, even if multiple tests are sold in one package. OTC COVID-19 test kits are not covered if they are purchased for resale or employee testing.

Coverage may be limited to certain brands of approved test kits. To obtain a current list of participating pharmacies and covered test kits, please contact Prime Therapeutics.

Individuals covered by the prescription drug benefit plan can obtain OTC COVID-19 test kits without any out-of-pocket expense or the need to submit a reimbursement form at:

- The pharmacy counter in a pharmacy participating in the Prime Therapeutics OTC COVID-19 testing program; or
- Online at www.myprime.com

If you purchase a covered OTC COVID-19 test kit at a retailer other than a participating pharmacy, at a general register in a pharmacy (that is, not at the pharmacy counter), at the pharmacy counter (but the pharmacy was unable to submit a claim on your behalf and you paid out-of-pocket), or online at www.myprime.com, you can submit a claim for reimbursement through Prime Therapeutics. To submit a claim for reimbursement, fill out the claim request form at www.myprime.com and submit the form for reimbursement along with the receipt from the retailer where the test kit was bought according to the instructions on the form.

4. Pharmacy Benefits

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 online Formulary. If you look for a particular drug and cannot find it in 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 University Medical and Pharmacy programs.
- The drug may be on tier 3 and will not show up on the printed Formulary, although it is included in the online Formulary. The employee copay for a tier 3 medication is \$75.
- The drug may be excluded from Plan coverage (see **5. Benefit Features, Q. Prescription Drugs**).

C. Tiered Copay Format

Drugs represented in the University Formulary have varying costs to the Member. Generic drugs typically are available at the lowest cost; brand-name drugs on the Formulary will generally cost more than generics; and brand-name drugs not on the Formulary 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.

Formulary Brand drugs in Tier 2 have an intermediate Member copayment. The Member's 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

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

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 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 occurs when a pharmacist selects the medication from among the medications (brand and generic) that are considered to be therapeutically equivalent. Unless expressly indicated by the prescriber as "dispense as written" or DAW, pharmacists in Minnesota may dispense generic drugs that, in their professional judgment, are therapeutically equivalent unless the patient requests otherwise. In instances when the prescriber indicates or the patient requests a prescription is DAW, 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) after 1984, and most generic approvals before 1984, have been based on a demonstration that the generic drug is therapeutically equivalent to the brand-name product.

4. Pharmacy Benefits

To gain FDA approval as a therapeutically equivalent product:

1. The generic drug must contain the same active ingredients, be the same strength, and be the same dosage form as the reference (brand-name) product
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 has met the FDA requirements for therapeutic equivalence, the generic drug can be substituted with the full expectation that the substituted product will produce the same clinical effect and have the same 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.

G. Mail Service Delivery

With Mail Service Delivery, you can submit prescriptions by mail or have prescribers fax-in prescriptions. The prescription

is then delivered directly to you. Members can receive a 90-day supply for two copays. Mail order forms and contact information can be found at www.myprime.com.

H. Medication Therapy Management

Medication Therapy Management (MTM) allows Plan 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 Plan members, including active employees, early retirees, disabled participants, and their dependents. You are eligible for the MTM Program if you meet any of these criteria: You take four or more Plan-covered prescriptions or 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 review all of your prescription, over-the-counter, and herbal medications to be sure they are appropriate, effective, safe, and convenient. The Plan 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 Plan 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. Find an MTM pharmacist at Medica.com/UofM. If you are enrolled in an ACO, talk to your Primary Care provider to find an MTM pharmacist in your ACO plan. The MTM pharmacist also does not need to be in the pharmacy where you fill prescriptions.

4. Pharmacy Benefits

MTM pharmacists serve all five campuses. The directory of MTM pharmacists is online at Medica.com/UofM.

I. Prior Authorization

Prior Authorization (PA) may be required in the Plan Pharmacy Program.

Certain drugs require a PA to encourage safe and clinically appropriate use. You can find out if your drug requires a PA by looking in the Formulary at www.myprime.com. Compound medications always require a PA.

It will be necessary for your prescriber or Medication Therapy Management (MTM) pharmacist to periodically complete and submit a PA form to Prime Therapeutics to request continued coverage of the selected drug. If the PA is approved by Prime Therapeutics, you can continue to take your drug at the normal copay for the medication. If the PA is not approved, you would need to pay the full cost of the drug or ask your provider to prescribe a different medication. You and your provider should be able to select an alternative medication that is included on the Plan Formulary.

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

Occasionally a University Medical and Pharmacy Program member, for reason of medical necessity, may need to take a drug that is subject to a higher copay under the benefit structure. If this occurs, you can ask Prime Therapeutics for a recommendation of an alternative drug that has a lower copay. You would then need to ask your provider whether a prescription for this medication is appropriate.

You can also get more information about the 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 PA request to Prime Therapeutics on your behalf. The PA form is available on the Prime Therapeutics website. Approved Step 2 drugs are available at the normal copayment for the medication. If the PA request is not approved by Prime Therapeutics, you may fill the prescription for the Step 2 medication, but you would need to pay the full cost of the drug. You may also ask your provider for a prescription for an alternative medication. If you decide that you prefer to remain on the higher Step 2 drug and do not try the Step 1 drug or request that your prescriber submit a PA, you can continue to take your Step 2 drug. However, the Plan will not cover the Step 2 drug, and you will pay the full cost of the prescription drug.

You can find out if your medication has Step Therapy, designated by ST after the drug name, by looking in the Formulary. You can also get more information about your Step Therapy Program at www.myprime.com.

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, people taking drugs to fight cancer may not finish their medicine because of the side effects, leading to wasted drugs.

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 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

4. Pharmacy Benefits

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 on a review by your physician and Fairview Specialty Pharmacy.

3. After six fills, 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 Committee

The University's 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 in the University of Minnesota Formulary.

When new drug products are added to the Formulary

New drugs that are generics will generally be added as soon as possible at the Generic Plus level. New brand drugs will not be covered until they are reviewed by the Prime Therapeutics P&T Committee and the Pharmacy Program Clinical Review Committee. Formulary decisions are communicated quarterly on the website at www.myprime.com.

M. Covered Drugs Policy

Pharmaceutical care is a vital component of the overall health care benefit provided for Plan Members. It is essential that the University 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. 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 as *covered* means that the Plan pays for part or all of the drug as a part of the University Pharmacy Program. Any drug 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.

Drugs, except as otherwise limited in this Summary of Benefits, will be designated as covered in any of these situations:

1. Prescription drugs 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 drugs approved by the 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 drugs when listed in the drug Formulary and prescribed by the patient's provider

N. Non-Covered Drugs

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

Drugs will be designated as *not covered* when one or 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. Pharmacy Benefits

4. Prescription drugs when the drug is not used according to FDA-approved labeling, unless such use is supported by well-documented, evidence-based research
 5. Prescription drugs used for cosmetic purposes as designated by the Plan
 6. Over-the-counter (OTC) or non-prescription drugs such as herbal, nutritional, and dietary supplements, except for insulin and other OTCs specifically listed in the Formulary
 7. Prescription drugs or drugs that are otherwise covered that require Prior Authorization (PA) when a PA has not been submitted by the Member's provider or approved by Prime Therapeutics
 8. Prescription drugs or drugs that are otherwise covered that require Step Therapy when the preceding steps (or drug products) have not been prescribed and used by the Member, or when a PA has not been submitted by the Member's provider or approved by Prime Therapeutics
3. Drugs where the only difference is the dosage forms (for example, tablet vs. capsule, or sustained release vs. regular drug product).
 4. Combination drugs, especially, but not exclusively, when the combination results in brand-name status for the combination drug product when each of the drugs would otherwise be available as a generic or at substantially lower prices
 5. Drugs that are found to be substantially less safe than alternative drugs without a substantial and counterbalancing improvement in effectiveness

Drugs 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 drugs in the same therapeutic category, especially when the not-covered drug costs substantially more than similar or better therapeutic alternatives.

Drugs may also be designated as *not covered* when one or more of the following situations exist:

1. Single source brand drugs 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. Drugs 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

Occasionally a Plan Member, due to a medical necessity, may need to take a drug that is not covered under the Pharmacy Program. If a drug is not covered, the Member can still get the medication, but they would need to pay the full cost. When this occurs, the Member's prescriber has the option to submit an appeal to Prime Therapeutics. If the appeal is approved by Prime Therapeutics, the Member will be able to receive the medication by paying the normal copay for the medication. If the appeal is denied, they can continue to get the medication but will need to pay the full cost of the drug that the pharmacy would charge someone without insurance. The Member can also ask their provider for an alternative medication that is covered on the Plan Formulary.

O. Additional Coverage Status Information

Covered drugs may be subject to various limitations, including cost sharing (for example, deductibles, copayments, and coinsurance), utilization management tools (for example, Prior Authorization, Step Therapy, or generic substitution), fraud and abuse review, and other benefit design tools (for example, utilization review, refill, quantity, dose, and duration limits). The coverage status of a drug may change (for example, from covered to not covered or vice versa) from time to time depending on availability of new evidence and research.

Certain prescription or other drug products may be excluded from coverage (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.

4. Pharmacy Benefits

P. Medical Pharmacy

Some medications are administered through the providers in Medica's provider network. These medications include drugs that need to be professionally administered by medical providers in a clinic, outpatient hospital, or inpatient hospital because they require one of the following:

- Intravenous (in the vein) infusion or injection
- Intrathecal (in the spine) infusion or injection
- Intramuscular (in the muscle) injection
- Intraocular (in the eye) injection
- As well as other drugs that, according to the manufacturer's recommendations, must typically be administered by a health care provider

The medications also include vaccinations, immunizations, or allergy shots that need to be administered by a medical professional to assure that the Member does not have an adverse reaction.

Some of these medications may require Prior Authorizations, or have other utilization management requirements. If a medical drug Prior Authorization is approved, it will pay based on the type of provider administering the medication (home, office, or hospital), whether it is in or out of network, and the coverage (deductible/copay/coinsurance). If a medical drug Prior Authorization is denied, the claim will be denied.

5. Benefit Features

KEY TERMS

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 pediatrics physicians. The Primary Care copay also applies to chiropractic, acupuncture, physical, occupational, and speech therapy, and behavioral health/mental health/substance use 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 Plan, 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. When the charges of an out-of-network provider are higher than the Allowed Amount, the Member is generally responsible for the difference except when the Member receives emergency care or treatment from a Nonparticipating Provider at an in-network hospital or facility. Refer to **Your Rights and Protections Against Surprise Medical Bills p. 58** for further information.

5. Benefit Features

A. Lifetime Maximum

Benefit	Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited

B. Deductible

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

5. Benefit Features

C. Out-of-Pocket Maximums

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

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 Medications out-of-pocket maximum.
- Prescription drug expenses for the treatment of fertility do not count toward any out-of-pocket maximum.
- Prescription drug expenses for growth hormones do not count toward any out-of-pocket maximum.
- The price difference between brand-name and generic drugs is your responsibility and is not applied toward the Out-of-Pocket Maximums for Prescription Medications 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 Medications.
- The amounts you pay for fertility 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 Medications, but does apply to the Out-of-Pocket Maximum for All Other Services.
- For out-of-network services, in all cases the charges above the Allowed Amount are your responsibility and do not count toward the Deductible or the Out-of-Pocket Maximum.

5. Benefit Features

D. Ambulance

Benefit	Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Ground and air ambulance to the nearest facility	80%	80%	80%	90% after deductible
Ambulance transfers between hospitals	100% after deductible	100% after deductible	100% after deductible	90% after deductible
Medical evacuations or transfers pre-authorized by Redpoint	100% after deductible	100% after deductible	100% after deductible	90% after deductible
Out-of-network	<ul style="list-style-type: none"> • Ground ambulance: For out-of-network coverage, refer to N. Out-of Network Care. • Air ambulance: If services would be covered if provided by a participating provider, then services are covered at in-network level (and any copayment, deductible, and coinsurance will apply to in-network deductible and out-of-pocket maximum). 			

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 Redpoint are not covered under the Medical Program and are not part of the cost of the 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. Non-emergency ambulance transportation that's arranged through an attending physician is eligible for coverage when certain criteria are met. Prior Authorization (approval in advance) is required before you receive non-emergency licensed air ambulance transportation.

Not Covered:

- Please refer to **7. Exclusions**

5. Benefit Features

E. Chiropractic Care

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

Notes:

- In-network benefits are available when Members receive services from providers in their plan's chiropractic Care Network.

Not Covered:

- Please refer to **7. Exclusions**

5. Benefit Features

F. Dental Care

Benefit	Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Emergency room dental care	In-network and out-of-network: 100% after \$100 copay per visit, waived if admitted	In-network and out-of-network: 100% after \$100 copay per visit, waived if admitted	In-network and out-of-network: 100% after \$100 copay per visit, waived if admitted	In-network and out-of-network: 90% after deductible
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 24 months of the injury.	100% after \$25 Primary/ \$35 Specialty copay	100% after \$20 Primary/ \$30 Specialty copay	100% after \$40 Primary/ \$50 Specialty copay	90% after deductible
Medically Necessary surgical or nonsurgical treatment of temporomandibular joint disorder (TMD) and craniomandibular disorders (CMD)	Inpatient and outpatient: 100% after deductible	Inpatient and outpatient: 100% after deductible	Inpatient and outpatient: 100% after deductible	90% after deductible
Medically Necessary outpatient dental services. Coverage is limited to dental services required for treatment of an underlying medical condition; for example, removal of teeth to complete radiation treatment for cancer of jaw, cysts, and lesions.	100% after deductible	100% after deductible	100% after deductible	90% after deductible

5. Benefit Features

F. Dental Care (Continued)

Benefit	Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
<p>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</p> <p>Anesthesia, inpatient, and outpatient hospital charges for dental care provided to a covered person who meets one of the following conditions:</p> <ul style="list-style-type: none"> • Is a child under age 5, or • Is severely disabled, or • Has a medical condition that requires hospitalization or general anesthesia for dental treatment. Coverage is limited to facility and anesthesia charges. <p>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.</p> <p>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 are 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.</p>	<p>Inpatient and outpatient: 100% after deductible</p>	<p>Inpatient and outpatient: 100% after deductible</p>	<p>Inpatient and outpatient: 100% after deductible</p>	<p>Inpatient and outpatient: 90% after deductible</p>
<p>For out-of-network coverage, refer to N. Out-of-Network Care</p>				
<p>Not covered:</p> <ul style="list-style-type: none"> • Charges for any appliance or service 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 7. Exclusions 				

Notes:

- For cleft lip and cleft palate, if a dependent child is also covered under a dental plan that 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.
- Eligible oral surgery services will be covered as an in-network benefit.

5. Benefit Features

G. Durable Medical Equipment and Supplies

Benefit	Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Durable Medical Equipment, which includes such items as wheelchairs, hospital beds, ventilators, oxygen equipment, and siderails				
Medical supplies, which includes splints, nebulizers, surgical stockings, casts, dressing, and catheter kits				
Wig coverage for hair loss caused by alopecia areata (limited to one annually)				
Covered prosthetics				
Initial lenses after surgery for: aphakia, keratoconus				
Initial lenses implanted during cataract surgery	80%	80%	80%	90% after deductible
Hearing aids and hearing aid batteries when prescribed by a participating audiologist or otolaryngologist				
Cochlear implants and bone-anchored hearing aids				
Enteral feedings, when the sole source of nutrition used to treat a life-threatening condition				
Special dietary treatment for phenylketonuria when prescribed/ recommended by a physician				

5. Benefit Features

G. Durable Medical Equipment and Supplies (Continued)

Benefit	Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
<p>Custom Foot Orthotics and custom orthopedic shoes that are part of a brace or custom molded insert that are Medically Necessary</p> <p>Diabetic supplies (insulin pumps and related supplies) Ostomy supplies</p> <p>Phototherapy devices and/or bulbs for treatment of seasonal affective disorder</p> <p>Breast pumps when prescribed or ordered by a physician and obtained through a participating DME provider</p>	80%	80%	80%	90% after deductible
Out-of-network	For out-of-network coverage, refer to N. Out-of-Network Care			

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.
- DME 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 DME will not be excluded solely because it is used outside the home.
- Quantity limits may apply to DME, prosthetics, and medical supplies.
- 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 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.
- Coverage for breast pump is limited to one purchase or rental per pregnancy.
- Coverage for the DexCom and FreeStyle Libre continuous glucose monitors (CGMs) are eligible under the pharmacy benefit. CGMs not available at a pharmacy are eligible under the medical plan.
- Covered hearing aid accessories include:
 - Receivers/receiver cable
 - Speakers
 - Stim tip (custom)
 - Stim tube

5. Benefit Features

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)
- 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
- Breast pump storage containers and freezer packs
- Hearing aid accessories that are not covered:
 - Warranty/service warranty
 - Wax guard
 - Bluetooth accessories
 1. Remote controls
 2. TV link/adaptor of any sort
- 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
- Other equipment and supplies the Claims Administrator determines not eligible for coverage
- Please refer to **7. Exclusions**

5. Benefit Features

H. Emergency Care

Benefit	Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
In-network and out-of-network services received during an emergency room visit from a hospital or facility-based emergency room	100% after \$100 copay per incident; copay waived if admitted within 24 hours	100% after \$100 copay per incident; copay waived if admitted within 24 hours	100% after \$100 copay per incident; copay waived if admitted within 24 hours	90% after deductible

Urgent Care

Benefit	Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
In-network and out-of-network services received during an Urgent Care visit	100% after \$25 copay per incident	100% after \$20 copay per incident	100% after \$40 copay per incident	90% after deductible
MRI and CT Scans	\$50 office visit copay	\$40 office visit copay	\$50 office visit copay	90% after deductible
All other lab and diagnostic imaging	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% after deductible

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 (for example, 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.

- **Emergency Medical Care and Out-of-Network Facilities:** If you are confined in an out-of-network facility as a result of an emergency, you will be eligible for in-network benefits until your attending physician agrees it is safe to transfer you to an in-network facility, except as described in **N. Out-of-Network Care** under the subheading Your Rights and Protections Against Surprise Medical Bills.

- **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 **8. Definitions.**

Not Covered:

- Please refer to **7. Exclusions**

5. Benefit Features

I. Home Health Care

Benefit	Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy, child health supervision services, phototherapy services, home health aide services, and laboratory services	100% after \$25 copay per home visit	100% after \$20 copay per home visit	100% after \$40 copay per home visit	90% after deductible
Total parenteral nutrition, intravenous therapy	100%	100%	100%	100%
Other home health services when provided in the Member's home. Member is homebound (i.e., unable to leave home without considerable effort due to a medical condition. Lack of transportation does not constitute homebound status.).	100% after \$25 copay per home visit	100% after \$20 copay per home visit	100% after \$40 copay per home visit	90% after deductible
Home-based intravenous therapy (homebound status does not apply)	100%	100%	100%	100%
Out-of-network	For out-of-network coverage, refer to N. Out-of-Network Care			

Notes:

- Home health services are covered only when they are:
 - Medically Necessary
 - Provided as rehabilitative or terminal care, and
 - Ordered by a physician, and included in the written home care plan
- IV therapy for prenatal and postnatal maternal and child health services, preterm high-risk pregnancy services and 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 home health visits within four days of discharge from the hospital if either the mother or the newborn child are confined for a period less than 48 hours (or 96 hours). See **Z. Annual Notifications** in this section.
- If you are a ventilator-dependent patient with communication needs and you require home care nursing services in your home, the plan will cover up to 120 hours of interpreter services/communication training provided by a home care nurse during the time you are hospitalized to assure adequate training of the hospital staff to communicate with you.
- Intermittent skilled care consists of visits up to two consecutive hours of care per date of service.

Not Covered:

- Charges for services received from a personal care attendant
- Extended hours home care, except for Members who have Medica coverage and are enrolled in the Medical Assistance Program
- 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 **7. Exclusions**

5. Benefit Features

J. Hospice Care

Benefit	Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Hospice services received through: <ul style="list-style-type: none"> Home care hospice program Hospice facility Hospital-based program that provides supportive and palliative treatment focus for a terminally ill Plan Member with a life expectancy of six months or less 	100%	100%	100%	90% after deductible
Medically Necessary inpatient services required for such things as pain and symptom management	100%	100%	100%	90% after deductible
Respite Care (in the home or an inpatient setting) of up to 10 days, to relieve caregivers as necessary to maintain the Member's comfort in his or her home	100%	100%	100%	90% after deductible
Out-of-network	For out-of-network coverage, refer to N. Out-of-Network Care			

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, and 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 **7. Exclusions**

5. Benefit Features

K. Inpatient Services

Benefit	Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
<ul style="list-style-type: none"> • Room and board and general nursing care • Intensive care and other special care units • Operating, recovery, and treatment rooms • Anesthesia • Blood and blood products (unless replaced) and blood derivatives • Prescription drugs or other medications and supplies used during a covered hospital admission • Lab and diagnostic imaging • Physical, occupational, radiation, and speech therapy • Physician and other professional medical services provided while in the hospital • General nursing care • Bariatric services or surgery • Treatment of cleft lip and cleft palate for a dependent child 	100% coverage after deductible ¹	100% coverage after deductible ¹	100% coverage after deductible ¹	90% after deductible ¹
Out-of-network	For out-of-network coverage, refer to N. Out-of-Network Care			

¹This is an individual deductible. In the event of a birth, there will be a separate admission deductible for each child.

Notes:

- Members seeking care for bariatric services or surgery must work with Claims Administrator to coordinate with Center of Excellence facilities.
- Inpatient hospital services received in a Member's home via a designated network home hospital program will be covered as an inpatient stay. This benefit is available for the Choice plans (Regional, National, HSA) and Mayo ACO plan only.

Not Covered:

- Please refer to **7. Exclusions**

5. Benefit Features

L. Maternity Services

Benefit	Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
<ul style="list-style-type: none"> Prenatal services First postnatal visit 	100% coverage	100% coverage	100% coverage	100% coverage
<ul style="list-style-type: none"> Additional postnatal services Home health care services following delivery 	100% coverage	100% coverage	100% coverage	90% coverage after deductible
<ul style="list-style-type: none"> Inpatient hospital stay for labor and delivery services Labor and delivery services at a free-standing birth center 	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% coverage after deductible
Out-of-network	For out-of-network coverage, refer to N. Out-of-Network Care			

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 home health visits within four 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 **7. 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.

5. Benefit Features

M. Behavioral Health—Mental Health

Benefit	Medica Elect/ Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Medically Necessary outpatient professional services for evaluation, crisis intervention, diagnosis, and treatment of mental disorders	100% after \$25 copay per visit	100% after \$20 copay per visit	100% after \$40 copay per visit	90% after deductible
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	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% after deductible
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.	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% after deductible
Admission to Intensive Residential Treatment Services depends on 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 Minnesota, Intensive Residential Treatment Service for adults)	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% after deductible
Intensive behavioral and developmental therapy for the treatment of autism spectrum disorder when provided in accordance with an individualized treatment plan prescribed by the covered person's treating physician or mental health professional. Examples of such therapy include, but are not limited to, early intensive developmental and behavioral intervention, applied behavioral analysis, intensive early intervention behavior therapy, intensive behavioral intervention, and Lovaas therapy.	Office visits/ outpatient professional services 100% after \$25 copay per visit, inpatient services 100% after deductible	Office visits/ outpatient professional services 100% after \$20 copay per visit, inpatient services 100% after deductible	Office visits/ outpatient professional services 100% after \$40 copay per visit, inpatient services 100% after deductible	Office visits/ outpatient professional services and inpatient services 90% after deductible
Out-of-network	For out-of-network coverage, refer to N. Out-of-Network Care			

5. Benefit Features

Notes:

- Family therapy is covered if recommended by a Provider treating a dependent child. Please contact your Medical Claims Administrator regarding this benefit.
- All behavioral health or mental health treatment must be provided by a licensed behavioral health or mental health professional operating within the scope of their license.
- In-network benefits are available when Members receive services from providers in their plan's behavioral/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 **7. Exclusions**

N. Out-of-Network Care

Benefit	Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Employee-only deductible	\$600	\$600	\$600	\$1,500
Family deductible per person	\$600	\$600	\$600	N/A
Family deductible maximum	\$1,200	\$1,200	\$1,200	\$3,000
Coinsurance after deductible is met See notes below for additional out-of-pocket expense information	70% up to annual Out-of- Pocket Maximum, then 100% coverage	70% up to annual Out-of- Pocket Maximum, then 100% coverage	70% up to annual Out-of- Pocket Maximum, then 100% coverage	70% up to annual Out-of- Pocket Maximum, then 100% coverage

Notes:

- For eligible medical services received from a licensed health care provider who is not in your plan's provider network
- You are not responsible for any amounts above what you would be required to pay for in-network benefits, unless you provide advance written consent, if your participating provider sent your lab work to an out-of-network laboratory for testing.
- Does not apply to Prescription Medications 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, except when you receive emergency care or receive treatment by a Nonparticipating Provider at an in-network hospital or facility, the charges above the Allowed Amount are your responsibility and do not count toward the Deductible or the Out-of-Pocket Maximum.

- All Members seeking services from Nonparticipating Providers may be subject to balance billing from the provider (except when receiving emergency care or receiving treatment by a Nonparticipating Provider at an in-network hospital or facility). 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.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

5. Benefit Features

N. Out-of-Network Care (Continued)

“**Out-of-network**” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“**Surprise billing**” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance).

You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can’t balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can’t balance bill you unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.

When balance billing isn’t allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network).

Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (Prior Authorization)

- Cover emergency services by out-of-network providers
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit

If you believe you’ve been wrongly billed, you may contact Minnesota Department of Commerce at 651-539-1600 or 1-800-657-3602.

Visit [Medica.com/MemberTips](https://www.medicare.com/MemberTips) for more information about your rights under federal law.

Nonparticipating Provider Reimbursement

The amount that the plan will pay to a Nonparticipating Provider for each benefit is based on one of the following, as determined by Medica:

1. A percentage of the amount Medicare would pay for the service in the location where the service is provided. Medica generally updates its data on the amount Medicare pays within 30 to 60 days after the Centers for Medicare and Medicaid Services updates its Medicare data
2. A percentage of the provider’s billed charge
3. A nationwide provider reimbursement database that considers prevailing reimbursement rates and/or marketplace charges for similar services in the geographic area in which the service is provided
4. An amount agreed upon between Medica and the Nonparticipating Provider
5. An amount required by the No Surprises Act of 2020, when applicable

Contact Medica for more information about which method pertains to your services, including the applicable percentage if a Medicare-based approach is used.

For certain benefits, you must pay a portion of the Nonparticipating Provider reimbursement amount as a copayment or coinsurance.

In addition, if the amount billed by the Nonparticipating Provider is greater than the Nonparticipating Provider reimbursement amount, the Nonparticipating Provider will likely bill you for the difference. This difference may be substantial, and it is in addition to any coinsurance or deductible amount you may be responsible for according to the terms described in this Plan. You will owe these amounts regardless of whether you previously reached your out-of-pocket maximum with amounts paid for other services. As a result, the amount you will be required to pay for services from a Nonparticipating Provider will likely be much higher than if you had received services from a network provider.

5. Benefit Features

O. Outpatient Services

Benefit	Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Surgery and anesthesia (including all services related to the surgery and delivered at the time of surgery)	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% after deductible
MRI and CT Scans	\$50 office visit copay	\$40 office visit copay	\$50 office visit copay	90% after deductible
All other lab and diagnostic imaging	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% after deductible
<ul style="list-style-type: none"> • Radiation and chemotherapy • Kidney dialysis • Pain management • Cardiac rehabilitation • Diabetes self-management training • Other non-surgical outpatient services not otherwise described above • Treatment of cleft lip and cleft palate for a dependent child 	100% after \$25 Primary/\$35 Specialty copay per visit	100% after \$20 Primary/\$30 Specialty copay per visit	100% after \$40 Primary/\$50 Specialty copay per visit	90% after deductible
Physical, occupational, and speech therapy	100% after \$25 copay per visit	100% after \$20 copay per visit	100% after \$40 copay per visit	90% after deductible
Sleep studies conducted at home	\$0	\$0	\$0	90% after deductible
Sleep studies conducted at a facility	100% after \$25 primary, \$35 specialty copay per visit	100% after \$20 primary, \$30 specialty copay per visit	100% after \$40 primary, \$50 specialty copay per visit	90% after deductible
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 **7. Exclusions**

5. Benefit Features

P. Physician Services

Benefit	Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Office visits for illness Surgical services performed during an office visit Services to diagnose an fertility condition Diabetes self-management training Hearing aid exams, audiometric tests, and audiologist evaluations provided by an audiologist or otolaryngologist Treatment of cleft lip and cleft palate Telehealth	\$25 Primary/ \$35 Specialty copay	\$20 Primary/ \$30 Specialty copay	\$40 Primary/ \$50 Specialty copay	90% after deductible
Convenience Clinic/Retail Health Clinic Virtual Care (telephonic or online)	\$15 copay	\$15 copay	\$20 copay	90% after deductible
MRI and CT Scans	\$50 office visit copay	\$40 office visit copay	\$50 office visit copay	90% after deductible
All other lab and diagnostic imaging	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% after deductible
Allergy testing and injections	100%	100%	100%	90% after deductible
Fertility treatment	80% to an annual maximum of \$5,000	80% to an annual maximum of \$5,000	80% to an annual maximum of \$5,000	80% to an annual maximum of \$5,000 after deductible
Out-of-network	For out-of-network coverage, refer to N. Out-of-Network Care			

Notes:

- The Plan covers surgery and pre- and postoperative care for an illness or injury. The Plan does not cover a charge separate from the surgery for pre- and postoperative care. If more than one surgical procedure is performed during the same operative session, the Plan covers them based on the Allowed Amount for each procedure.
- Fertility treatment and assisted reproductive technology services including IVF, GIFT, and ZIFT for covered persons diagnosed with fertility are covered at 80% coinsurance and limited to an annual maximum of \$5,000. The amounts you pay for fertility 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 fertility 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 fertility
- Separate charges for pre- and postoperative care
- 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.
- Please refer to **7. Exclusions**

5. Benefit Features

Q. Prescription Drugs

Benefit	Medica Elect/ Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
30-day supply (including insulin); available through Pharmacy Benefits Managers' network pharmacies Selected preventive medications specified in the Affordable Care Act and contraceptives in the Generic Plus category	\$0 copay	\$0 copay	\$0 copay	100%
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)	\$10 copay	\$10 copay	\$10 copay	Prescriptions are covered in the HSA and at 90% in medical plan after deductible
Formulary brand (Tier 2) drugs (includes all other Formulary brand drugs)	\$30 copay	\$30 copay	\$30 copay	Prescriptions are covered in the HSA and at 90% in medical plan, after deductible
Non-Formulary (Tier 3) drugs (includes covered brand drugs not listed on Formulary)	\$75 copay	\$75 copay	\$75 copay	Prescriptions are covered in the HSA and at 90% in medical plan, after deductible
Purchase of brand drug when chemically equivalent generic is available. The difference in cost does not apply toward the annual Out-of-Pocket Maximum.	Pay the generic copay and difference in cost between the brand drug and the generic drug	Pay the generic copay and difference in cost between the brand drug and the generic drug	Pay the generic copay and difference in cost between the brand drug and the generic drug	Prescriptions are covered in the HSA and at 90% in medical plan, after deductible ¹
Drugs purchased by mail order	3-month supply available for two copays	3-month supply available for two copays	3-month supply available for two copays	Prescriptions are covered in the HSA and at 90% in medical plan, after deductible
Implantable and injectable birth control drugs and devices	100% after office visit copay or surgical deductible	100% after office visit copay or surgical deductible	100% after office visit copay or surgical deductible	100%, with office or surgical visit paid at 90%, after deductible

¹ When in the coinsurance level, pay 10% coinsurance based on generic price in addition to difference in cost between the brand drug and the generic drug.

5. Benefit Features

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 fertility services, see notes in **P. Physician Services**.
- Growth hormones do not apply to Prescription Drugs Out-of-Pocket Maximum.
- Special dietary treatment for phenylketonuria when prescribed or recommended by a physician does not apply to Prescription Drugs Out-of-Pocket Maximum.
- The Formulary is a comprehensive list of preferred drugs selected for 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.
- Preferred diabetic meters are available at no cost with test strips at the tier 1 \$10 copay. Other diabetic meters and test strips are covered under the Pharmacy Program with a tier 3 \$75 copay. For more information, contact Prime Therapeutics, the Pharmacy benefit manager.
- Diabetic supplies are covered for type 1 and type 2 diabetes as well as for gestational diabetes
- Continuous glucose monitors (CGMs) are covered for individuals with type 1 diabetes. DexCom and FreeStyle Libre are covered under the Pharmacy Program with a tier 2 \$30 copay or, for the HSA plan, a 10% coinsurance after the deductible is met. All other CGMs are covered as Durable Medical Equipment. See **G. Durable Medical Equipment and Supplies**.
- 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.
- DAW does not override the Non-Formulary copayment.

5. Benefit Features

Q. Prescription Drugs (Continued)

Over-the-Counter Preventive Drug List under Affordable Care Act (\$0 copay)

In accordance with requirements of the Affordable Care Act (ACA), the Plan 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
- 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) 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 **4. 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 **7. Exclusions**

5. Benefit Features

R. Preventive Care

Benefit	Medica Elect/ Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
<ul style="list-style-type: none"> • Routine physical exams • Routine gynecological exams • Routine cancer screening • Laboratory services • Immunizations and vaccinations; includes those needed for travel • Routine hearing exams • Routine eye exams • Prenatal services • Postnatal services • Professional voluntary family planning services • Lactation counseling and supplies, such as breast pumps • Counseling for human immunodeficiency virus (HIV), sexually transmitted diseases, and domestic or other personal violence • 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 HIV, BRCA genetic testing and related genetic counseling (when appropriate), and sterilization • Obesity prevention counseling for midlife (age 40 to 60) women with normal or overweight body mass index (18.5-29.9 kg/m2) 	100%	100%	100%	100% Deductible does not apply ¹
Out-of-network	For out-of-network coverage, refer to N. Out-of-Network Care			

¹Labor, 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 routine eye exam and one 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
- Preventive mammograms include, but are not limited to, coverage for women at risk for breast cancer. "At risk for breast cancer" means 1) having a family history with one or more first- or second-degree relatives with breast cancer; 2) testing positive for BRCA1 or BRCA2 mutations; 3) having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of

Radiology; or 4) having a previous diagnosis of breast cancer.

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 their fitting or supply (except when eligible under **G. Durable Medical Equipment and Supplies**), including the treatment of refractive errors such as radial keratotomy
- Please refer to **7. Exclusions**

5. Benefit Features

S. Reconstructive Surgery

Benefit	Medica Elect/ Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
<ul style="list-style-type: none"> • Surgery to repair a defect caused by an accidental injury • Reconstructive surgery incidental to or following surgery resulting from injury, sickness, or disease of that part of the body • 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 • Reconstructive surgery to correct a child's birth defect (other than a developmental defect), for dependent children • Treatment of cleft lip and palate for a child under age 18 (See F. Dental Care) • Elimination or maximum feasible treatment of port wine stain 	<p>Inpatient: 100% coverage after deductible</p> <p>Outpatient: 100% coverage after deductible</p>	<p>Inpatient: 100% coverage after deductible</p> <p>Outpatient: 100% coverage after deductible</p>	<p>Inpatient: 100% coverage after deductible</p> <p>Outpatient: 100% coverage after deductible</p>	<p>Inpatient: 90% after deductible</p> <p>Outpatient: 90% after deductible</p>
Out-of-network	For out-of-network coverage, refer to N. Out-of-Network Care			

Note:

- See **Z. Annual Notifications** in this **5. Benefit Features** section

Not Covered:

- Charges for cosmetic health services or any related services, except as provided above
- Please refer to **7. Exclusions**

Reconstructive Surgery: Treatment for Gender Dysphoria and Gender Affirmation

All surgical gender-affirming services require Prior Authorization by the Claims Administrator. Non-surgical services are not subject to Prior Authorization. Case management in collaboration with a nurse case manager is available through the Claims Administrator.

Benefits are provided for services for or related to treatment leading to or in connection with gender affirmation surgery, hormone therapy, related preparation and follow-up treatment, care, and counseling.

Benefits are provided for Medically Necessary and Appropriate services as determined by the Claims Administrator. The Medical Necessity criteria is in the Claims Administrator's Utilization Management Policy at medica.com/providers/policies-and-guidelines/ and Medical Necessity criteria specific to primary sexual characteristics is not applicable to procedures for secondary sexual characteristics. Coverage decisions are based on published evidence including medical standards set forth by nationally recognized medical experts in the transgender health field.

5. Benefit Features

S. Reconstructive Surgery (Continued)

Additional coverage for secondary procedures:

When Medically Necessary and supported by required documentation, the following secondary sexual characteristic (masculinizing or feminizing) gender-affirming procedures are covered:

- Electrolysis or laser treatment for facial hair removal
- Voice therapy
- Voice modification surgery when voice/speech therapy has been ineffective
- Reduction thyroid chondroplasty or trachea shaving (reduction of Adam's apple)
- Facial feminization or masculinization surgery, including the following procedures
- Hairline advancement
- Forehead contouring/reconstruction
- Implant augmentation/reduction of the forehead and brow
- Blepharoplasty
- Brow lift
- Cheek augmentation with implants or autologous fat grafting
- Rhinoplasty
- Upper lip lift
- Lip augmentation with tissue augmentation or fat graft
- Implant augmentation/reduction of the mandible and chin
- Neck lift
- Face lift or liposuction (only as needed in conjunction with the above facial procedures)

Additional coverage for primary procedures:

- Electrolysis or laser hair removal to treat tissue donor sites for planned genital surgery

5. Benefit Features

T. Rehabilitative and Habilitative Services

Benefit	Medica Elect/ Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Rehabilitative or habilitative physical, speech, and occupational therapy services received in a clinic, office, or as an outpatient	100% after \$25 copay per visit	100% after \$20 copay per visit	100% after \$40 copay per visit	90% after deductible
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	100% after \$25 copay per visit	100% after \$20 copay per visit	100% after \$40 copay per visit	90% after deductible
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 **7. Exclusions**

5. Benefit Features

U. Skilled Nursing Facilities

Benefit	Medica Elect/ Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
<p>The Plans cover the services listed below at:</p> <ul style="list-style-type: none"> • Skilled Care ordered by a physician • Room and board • General nursing care • Prescription Drugs or other medications and supplies used during a covered admission, and billed through the skilled nursing facility • Physical, occupational, and speech therapy • Respiratory therapy 	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% after deductible
Out-of-network	For out-of-network coverage, refer to N. Out-of-Network Care			

Not Covered:

Please refer to **7. Exclusions**

5. Benefit Features

V. Specified Out-of-Network Services

Benefit	Medica Elect/ Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
<p>The Plans cover the following services at the in-network coverage level when you receive them from an Out-of-Network provider:</p> <ul style="list-style-type: none"> • Voluntary family planning of the conception and bearing of children • Provider visits and tests to make a diagnosis of infertility • Testing and treatment of sexually transmitted diseases • Testing for AIDS and other HIV-related conditions 	<p>Coverage level is same as corresponding benefit, depending on type of service provided, such as Physician Services.</p>			

5. Benefit Features

W. Substance Use Disorder

Benefit	Medica Elect/ Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Medically Necessary outpatient professional services for diagnosis and treatment of Substance Use Disorders	100% after \$25 copay per office visit	100% after \$20 copay per office visit	100% after \$40 copay per office visit	90% after deductible
Medically Necessary inpatient and professional services for Substance Use Disorders that require the level of care provided in a hospital or other licensed residential treatment center	100% after deductible	100% after deductible	100% after deductible	90% after deductible
Out-of-network	For out-of-network coverage, refer to N. Out-of-Network Care			

Notes:

- Covered outpatient professional services for Substance Use Disorders 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 multifamily therapy provided in an outpatient 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 Use Disorders must be provided in a hospital or licensed residential treatment center and can include the following:
 - Detoxification services
 - Semiprivate 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 use rehabilitation
- In-network benefits when Members receive services from providers in their plan’s Substance Use Disorder network
- Methadone maintenance therapy and other equivalents, with a copay or coinsurance based on the plan option

Not Covered:

- Charges for services or confinements 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 Use Disorder treatment services
- Please refer to **7. Exclusions**

5. Benefit Features

X. Transplant Services

Benefit	Medica Elect/ Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Transplants and certain related services for the following: <ul style="list-style-type: none"> • Bone marrow / stem cell support • Cornea • Heart • Heart-lung • Kidney • Liver • Lung • Pancreas 	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% after deductible
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			

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.
- Airfare is reimbursable only if the travel distance from your home to the transplant facility is 200 miles or more.
- Transportation and lodging reimbursement for you and a companion is covered when you receive approved transplant services at a facility more than 50 miles from where you live.
 - a. Transportation for you and one companion traveling on the same day to or from a 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.
 - 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.

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 **7. Exclusions**

5. Benefit Features

Y. Harmful Use of Medical Services

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 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 get 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 get approval for benefits not available from your coordinating health care providers
2. How to obtain emergency care
3. When these restrictions end

5. Benefit Features

Z. Annual Notifications

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:

- 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 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.

6. Medical Prior Authorization

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 Member service phone number for your plan found on the back of your ID card.

If you are a new Medica Member and have a Prior Authorization for services from your former health plan, Medica will accept that Prior Authorization for at least the first 60 days of coverage under this Plan. To get coverage for this 60-day period, you or your provider must send Medica documentation of the previous Prior Authorization. For coverage to continue after the 60-day period, you, someone on your behalf, or your attending provider should submit a request for Prior Authorization to Medica before the end of this 60-day period.

Emergency services do not require Prior Authorization.

You do not require Prior Authorization for 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 Member 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 Member Service to request Prior Authorization for services or supplies received from a non-network provider.

We recommend that you confirm with Member 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:

- Solid organ and blood and 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
- Gender dysphoria and gender affirmation surgery, sex hormones related to surgery, related preparation, and follow-up treatment, care, and counseling
- Certain reconstructive or restorative surgery procedures
- Certain drugs and Biologics
- Certain home health care services
- Certain medical supplies and Durable Medical Equipment
- Certain behavioral health or mental health services
- Certain substance use disorder services
- Certain outpatient surgical procedures
- Certain genetic tests
- Certain imaging services (for example: PET scans and proton beam therapy)
- Skilled nursing facility services

Pregnancy and 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 appropriate to your medical circumstances, provided all information reasonably necessary to make a decision has been given to Medica.

7. Exclusions

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 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 **5. 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 **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 **5. Benefit Features** section under Behavioral Health—Mental Health
13. Charges for **recreational or educational therapy**, or forms of self-care or self-help training (non-medical), including, but not limited to, health club memberships and smoking cessation programs, aerobic conditioning, therapeutic exercises, work hardening programs, conversion therapy, and all related material and products for these programs. For this purpose, “conversion therapy” means any practice by a mental health practitioner or mental health professional that seeks to change a person’s sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward people regardless of gender. Conversion therapy does not include counseling that provides assistance to a person undergoing gender transition. It also does not include counseling that provides acceptance, support, and understanding of a person or facilitates a person’s coping, social support, and identity exploration and development, including sexual-orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as the counseling does not seek to change the person’s sexual orientation or gender identity.
14. Charges for **lenses, frames, contact lenses** or other fabricated optical devices or professional services for the fitting or supply thereof
15. Charges for **lasik**, keratotomy, and keratorefractive surgeries
16. Charges for services that are **normally provided without charge**, including services of the clergy
17. Charges for **autopsies**
18. **Nonprescription and/or over-the-counter drugs or medicines**, except as specified in the 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

7. Exclusions

19. **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
20. Charges for **services a Provider gives him/herself or a close relative** (such as spouse, brother, sister, parent, or child)
21. Charges for **dental or oral care** except for those specified in the **5. Benefit Features** section
22. Charges for any appliance or service for or related to **dental implants**, including hospital charges
23. Charges for **personal comfort items** such as telephone, television, barber, beauty services, and guest services
24. 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
25. **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 **5. Benefit Features** section
26. 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 **5. Benefit Features** section
27. Charges for **travel, transportation, or living expenses**, except as described in the **5. Benefit Features**, section **X. Transplant Services**
28. Charges for **services provided before your coverage is effective or after your coverage terminates** even though your illness started while coverage was in force
29. Charges for **private-duty nursing**, except as described in **I. Home Health Care** coverage
30. Charges for **weight loss programs**, including program fees or dues, nutritional supplements, food, over-the-counter appetite suppressants, vitamins, and exercise therapy
31. 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
32. 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
33. Charges for **inpatient admission to the hospital for diagnostic tests** that can be performed on an outpatient basis
34. Charges **for injections that can be self-administered**; however, in some cases the prescription drug may be covered as specified in the **5. Benefit Features** section
35. 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 before receiving the services
36. Charges for voluntary **reversal of sterilization**
37. Charges for **long-term storage of ova or sperm**
38. **Massage therapy** for the purpose of a Member's comfort or convenience
39. The portion of a billed charge for an otherwise Covered Service by a provider that is **in excess of the fair and reasonable charges**
40. **Nutritional supplements**, over-the-counter electrolyte supplements, and infant formula, except as required by Minnesota law Chapter 62A.26 for PKU treatment
41. **Genetic counseling and genetics studies** that not Medically Necessary
42. 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

7. Exclusions

43. **Extended hours home care**, except for Members who have Medica coverage and are enrolled in the Medical Assistance Program
44. Services for or related to **functional capacity evaluations** for vocational purposes and/or determination of disability or pension benefits
45. Charges for elective, non-emergency **home childbirth** deliveries
46. Separate charges for **childbirth education** classes when billed separately
47. Services for **vision therapy**, except for limited services considered Medically Necessary based on the guidelines of the Plan
48. **Telephonic substance use treatment** services, unless in accordance with the Claims Administrator's telemedicine policies and procedures
49. Services for **telephone psychotherapy**, unless provided as a behavioral health service in accordance with the Medical Claims Administrator's telemedicine policies and procedures
50. Services solely related to the **treatment of snoring**
51. Chemotherapy or radiation therapy, together with all related services, supplies, drugs, and aftercare, when their administering is expected to result in **damage to or suppression of the bone marrow**, the blood or blood-forming systems, warranting 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
52. 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
53. Charges for services for or related to **systemic candidiasis, homeopathy, immunoaugmentative therapy, or chelation therapy** that the Claims Administrator determines is not Medically Necessary
54. Charges for physical exams for obtaining **employment, licensure, or insurance**
55. Services to confine a **person under chemical influence** when no medical services are required regardless of where the services are received
56. Services to treat injuries or illness as a result of **committing a crime or attempting to commit a crime**
57. Laboratory testing performed in response to **direct-to-consumer marketing** and not under the direction of a physician
58. **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
59. Charges for **Orthognathic Surgery** done for cosmetic purposes
60. Charges and services that are rendered to a Member by a **non-licensed provider**
61. **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
62. **Services related to adoption**
63. **Any form, mixture, or preparation of cannabis for medical or therapeutic use and any device or supplies related to its administration**
64. **Charges for anesthesia for removing impacted teeth**
65. **Charges and services for injuries that occur while on military duty or as a result of war.** This exclusion does not apply if you are a civilian.

8. 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. If you go to an out-of-network provider, the Allowed Amount is established according to the Usual & Customary Charge. 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 Primary Care clinic (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 5.** of this Summary of Benefits that lists 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, allergenics, 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 group 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 University Medical Program Members get safe, quality care related to certain complex procedures. This initiative identifies experienced surgeons and comprehensive surgical facilities that provide services for transplants and bariatric care, including surgery for morbid obesity.

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

Claims Administrator

Medica Self-Insured (MSI) is the entity that handles the day-to-day operations of the University Medical Plan options, along with the pharmacy benefit manager, Prime Therapeutics and Fairview Specialty Pharmacy, and the health improvement program administrator, Virgin Pulse. 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 your 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.

Convenience Care/Retail Health Clinic

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

8. Definitions

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) a condition requiring professional health services immediately that a prudent layperson would believe necessary to preserve life or stabilize health.

Foot Orthotic

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 for quality and efficacy by a professional committee of physicians and pharmacists.

Health Savings Account (HSA)

Money 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 University Medical Plan option that includes an HSA.

8. Definitions

Hospice Care

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. In-Network also refers to 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 about 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 that 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.

Mental Health Residential Treatment Services

Consistent with the covered person's diagnosis and presentation, and the level and intensity of care as indicated by external clinical guidelines, a licensed or certified residential mental health treatment program must provide the following:

1. A 24-hour-a-day, structured setting, inclusive of room and board, and
2. The program administers at least the following basic services:
 - a. A combination of group, family, and individual counseling provided by a clinically or appropriately licensed mental health professional and/or graduate level professional in the process of obtaining licensure working under the oversight of a licensed mental health practitioner
 - b. On-site or virtual psychiatric assessment within 48 hours of admission
 - c. Psychiatric follow-up visits at least once a week provided by a licensed psychiatric prescriber for mental health treatment
 - d. Individual and/or family therapy a minimum of once a week provided by a licensed mental health professional for mental health treatment
 - e. Weekly client education (such as mindfulness or reflective journaling)
 - f. Other services specific to mental health treatment
 - g. Adequate nursing coverage for the specific level of care
 - h. A written, specific, and person-centered treatment plan with viable discharge planning to support ongoing recovery efforts

Please note: Individual, family, and group counseling and therapy must be based on evidence-based modalities with proven efficacy. Therapy using modalities with unproven efficacy must occur in addition to the evidence-based practices.

8. Definitions

Nonparticipating Provider

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

Out-of-Network Care

Care received from a Nonparticipating Provider. All 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. Refer to the **5. Benefit Features** Chart for the applicable coverage.

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.

Plan

The plan of benefits established by the University Plan Sponsor.

Plan Sponsor

The Board of Regents of the University of Minnesota.

Plan Year

The period from January 1 to December 31.

Prescription Medication Out-of-Pocket Maximum

The most you must pay toward the Allowed Amount for prescription medications per Plan Year.

Prescription Medication

Medications, including insulin, or Prescription Drugs that are required by federal law to be dispensed only by prescription of a health professional 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 performed because of symptoms, such as rectal bleeding, coughing up blood, or skin abnormalities, 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 body part, or 2) congenital disease or anomaly that 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.

8. Definitions

Respite Care

Short-term inpatient or home care provided to the patient to relieve family members or others 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 Plan options allow self-referral and others do not. See **3. Plan Descriptions** for more information.

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 that 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 or Specialty Drugs

Specialty pharmacy medications are bioengineered 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 Use Disorder Residential Treatment Services

Substance use disorder residential treatment services are services from a licensed chemical dependency rehabilitation program that provides intensive therapeutic services following detoxification:

1. A 24-hour-a-day, structured setting, inclusive of room and board, and
2. The program administers at least the following basic services:
 - a. A combination of group, family, and individual counseling provided by a clinically or appropriately licensed mental health professional and/or graduate level professional in the process of obtaining licensure working under the oversight of a licensed mental health professional
 - b. Completion of a substance use disorder or chemical health assessment
 - c. Access to psychiatric services provided by a licensed psychiatric prescriber for mental health treatment as clinically indicated for substance use disorder treatment
 - d. Individual or family therapy a minimum of once a week provided by a licensed mental health professional for substance use disorder or mental health treatment
 - e. Weekly client education (such as mindfulness, reflective journaling, sleep hygiene, anger management, or safe sex practices)
 - f. Other services specific to mental health treatment and/or substance use disorder treatment
 - g. Adequate nursing coverage for the specific level of care
 - h. A written, specific, and person-centered treatment plan with viable discharge planning to support ongoing recovery efforts

Please note: Individual, family, and group counseling and therapy must be based on evidence-based modalities with proven efficacy. Therapy using modalities with unproven efficacy must occur in addition to the evidence-based practices.

8. Definitions

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 year.

Telehealth

Telehealth is the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. An originating site includes a health care facility at which a patient is located at the time the services are provided by means of Telehealth. A distant site means a site at which a licensed health care provider is located while providing health care services or consultations by means of Telehealth. A communication between a licensed health care provider and a patient that consists solely of an email or facsimile transmission does not constitute Telehealth consultations or services.

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 or of his or her health.

Usual and 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.)

Amounts billed above the Usual and Customary rate by an out-of-network provider will deny as Member liability and will not count toward the Member's copay, coinsurance, deductible, or maximum out-of-pocket. A Member can contact Medica to request the U&C Charge in advance of a procedure.

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 card and any covered dependents.

9. Travel Program

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 member service phone number listed on the back of your Medica Member ID card.

Notes:

- 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 the OHR Contact Center to complete a waiver form. This is not available to Medica ACO Plan Members as all services will be coordinated by the ACO provider.

10. Emergency Travel Assistance Program

Your Basic Life Insurance plan includes automatic enrollment in Redpoint, an emergency assistance program, for you and your covered family members, including spouses and children under age 26. This service provides 24/7 multilingual assistance plus immediate help in a travel-related emergency, whether you are 100 or more miles from home or traveling internationally. University Medical Plan Members can have emergency medical services covered for themselves and their dependents while traveling, and Redpoint will assist with arranging related services.

A. Redpoint Emergency Travel Assistance Services

- **Help at every step.** Redpoint offers pre-trip resources, emergency assistance and evacuation services, as well as intelligence and travel assistance services.
- **Worldwide medical and dental care referrals.** Offers assistance in locating the nearest appropriate health care provider.
- **Dispatch of doctors or specialists and coordination of admission into a hospital.*** Redpoint arranges needed medical evacuation to the nearest appropriate hospital. However, only University Medical Plan participants will have coverage for related medical care.
- **Emergency travel assistance.** Flight arrangements, including arranging for tickets, visas, and logistical arrangements in case you are involved in a political emergency or a natural disaster.

- **Evacuation due to a political emergency or natural disaster:** University to pay evacuation costs.
- **Medical emergency:** Traveler must be covered by the University Medical benefit for travel cost coverage.

**Medical services are only available for University Medical Plan participants. If you participate in the University's Basic Life Insurance benefit but do not participate in the University Medical Plan, you will pay for related medical services.*

B. How to Contact Redpoint

For questions and help with medical, travel, and security problems, call Redpoint at 855-516-5433 (U.S. and Canada), or +1-415-484-4677 (collect calls accepted) or email operations@RedpointResolutions.com.

If you need an ID card for yourself or another covered family member, call or email Redpoint directly.

A multilingual assistance coordinator will ask for your name, your company or group name, and a description of your situation.

You are encouraged to go to the Employee Benefits website at <https://z.umn.edu/emergencytravelmed> for a summary of the program definitions, conditions, and limitations.

11. Convenience Care/Retail Health Clinic

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 and other convenience clinics across the state. The clinics are in-network providers for the University Medical Program options. However, Gopher Quick Clinic is not available to Medica ACO Members except for participants in the VantagePlus network.

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 coinsurance, if applicable.

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 the Twin Cities Campus

The Gopher Quick Clinic offers fast, convenient health care services to faculty, staff, and their dependents who are enrolled in a University 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 boynton.umn.edu.

B. Medica CallLink Nurse Line

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.

12. Virtual Care

Virtual Care 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 time-saving 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 is 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 University 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 or coinsurance 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*.

Your options may include:

- Amwell (amwell.com), 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.
- virtuwel[®] (virtuwel.com), a 24/7 online clinic available in selected 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.
- OnCare, a Virtual Care provider for Members in VantagePlus with Medica ACO (featuring providers from Fairview, HealthEast, North Memorial, and many independent clinics including Boynton Health and University of Minnesota Physicians).
- Your clinic—check to see if Virtual Care is offered and learn how you can connect with your provider online or by e-visit.

Telehealth

In addition to Virtual Care, the Plan provides coverage for Telehealth benefits that are Medically Necessary. Telehealth benefits generally consist of health care services or consultations that occur while you are at a health care facility and your licensed health care provider is at the provider's office. The plan provides the same coverage (and reimbursement) for Telehealth as in-person visits with a health care provider. Contact your Medical Claims Administrator for more details.

13. Wellbeing Program

September 1, 2022–August 31, 2023

Take advantage of the University’s wellbeing resources and gain rewards throughout the year.

The University of Minnesota Wellbeing Program offers programs and resources that focus on the following eight dimensions of health: physical, emotional, financial, spiritual, occupational, intellectual, environmental, and social.

The Wellbeing Program exists to provide open, flexible, customizable ways and resources to help University employees live balanced, fulfilling lives based on their own goals and needs.

Program year: September 1, 2022–August 31, 2023

This program allows you to earn points that add up to real savings on your 2024 medical rates—either \$500 or \$750 a year depending on whether you have a spouse covered under your medical plan.

If your coverage is:	You need to earn at least:	To save this amount in 2024:
Employee Only	5,000 points	\$500
Employee and Children	5,000 points	\$500
Employee and Spouse With or Without Children	7,500 points (If covered spouse chooses to participate, they must earn all 2,500 points toward 7,500 incentive)	\$750

Bonus Points + Random Prize Drawing: Beyond reaching the incentive levels in the portal, each level you reach earns you more entries into a random prize drawing at the end of the program year to win \$100 in Pulse Cash.

How to Sign Up

Once your medical benefits are effective (first of the month following your start date), you will be eligible to enroll in the Wellbeing Program through Virgin Pulse. Once you are eligible, you will receive a notification email from Virgin Pulse, or you can follow the steps at z.umn.edu/WellbeingProgramRegistration to register yourself, and your spouse if applicable. Participation in the program is a voluntary choice requiring action.

After you register your account, you can sign in using single-sign-on at z.umn.edu/WellbeingPgrm. The full list of earning and program options can be found under the Home tab on the Virgin Pulse portal under “Rewards.”

How do you receive the \$500 or \$750 reward?

Your reward will be spread across your paychecks in 2024 through reduced medical plan rates.

Adding or removing a spouse to your medical plan:

If you change your medical plan coverage during the year by either adding or removing a spouse, you will need to earn points corresponding to your new status. For example, if you add your spouse in June to the medical plan, you will need to get a total of 7,500 points by August 31, 2023, instead of 5,000 points.

Questions about the program?

For questions about registration issues, the Virgin Pulse portal, syncing devices, or last year’s points, contact Virgin Pulse:

UMN-specific customer service line: 1-833-996-1870
(Monday-Friday, 7:00 a.m.–8:00 p.m. CT; accepts TTY services)

Website: support.virginpulse.com

Live chat: member.virginpulse.com
(Monday-Friday, 8:00 a.m.–9:00 p.m. EST)

Email: support@virginpulse.com

For UMN-specific programs, contact wellness@umn.edu.

14. 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 the order that claims are processed by each plan 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.

14. 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 Plan 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

14. 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.

15. Disputing a Determination Concerning Eligibility, Enrollment, or Other Administrative Issue

The University's plan document for pretax group health insurance, University of Minnesota Pre-Tax Benefits Plan for Eligible Employees, does not allow for enrollments outside of Open Enrollment or without a qualifying event under Section 125 of the Internal Revenue Code.

You have 30 days:

- As a **new employee** or **newly benefits-eligible employee** from your date of employment, your newly benefits-eligible job, or, if you are an employee who has worked less than one year and are described in **2.K. Affordable Care Act (ACA) Special Enrollment**, the benefits eligibility date specified in your notice of eligibility to enroll or make changes
- Of a **qualified family status** change to add or remove coverage for spouse and dependents
- From **date of birth or placement for adoption** to add a child
- To submit **dependent eligibility verification** documentation for an enrolled dependent
- After losing eligibility for coverage under another group health plan to enroll yourself and your dependents
- After losing employer contributions to another group health plan to enroll yourself and your dependents

You have 60 days:

- After a loss of eligibility for coverage under Medicaid or CHIP to enroll yourself and/or your dependents
- After qualifying for state assistance in paying group health plan premiums to enroll yourself and/or your dependents

There are limited options to make changes outside of the regulations, except in cases of administrative error (for example, a system entry error, etc.).

If you are disputing a determination concerning an eligibility, enrollment, or other administrative issue and the determination does not involve a specific claim for benefits, you may contact the Office of Human Resources (OHR) Contact 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 Office of Human Resources, University of Minnesota, 100 Donhowe Building, 319 15th Avenue SE, Minneapolis, MN 55455-0103. You must contact the OHR Contact Center within 90 days of the date that the eligibility, enrollment, or other administrative issue first became apparent.

The OHR Contact Center representative will assist in trying to resolve the concern informally. If you are unable to resolve your concern and wish to pursue the matter, you must submit a written request for review, including the concerns you have about your eligibility, enrollment, or other administrative issue, plus supporting documentation. You will receive a telephone call or written response from the OHR Contact Center as soon as possible, but not later than 30 days after the University receives your request for review.

16. Disputing a Preliminary Claim Review or Claim Payment Denial

If your claim for benefit payments under the Plan is wholly or partially denied, if the care 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 help you try to resolve the concern informally.

If you are unable to resolve your concern and want 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.

1) 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.

2) If waiting the standard 30-day turnaround time might jeopardize your life, health, or ability to regain maximum function, or if this time frame 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
- 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 Center for Consumer Information and Insurance Oversight 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 OHR Contact Center.

B. Appealing Decision of the Medical or Pharmacy Claims Administrator

When the Claims Administrator denies a claim, a Prior Authorization request, or a request for services or care, you can ask to have a decision reconsidered.

1. How to Provide Relevant Information for an Appeal

- Call or write to the Claims Administrator to request an appeal:
 - Medica Member Service: 952-992-1814 or 877-252-5558 (TTY: 711)
 - Medica Member Service
Route 0501
PO Box 9310
Minneapolis, MN 55440-9310

16. Disputing a Preliminary Claim Review or Claim Payment Denial

Make your request for an appeal within 180 days from the date of the decision

Show that you followed procedure

- Provide your personal narrative of what took place, including the outcome.
- Contact Claims Administrator to request paperwork related to your appeal.
- Provide dates and method of any correspondence—by phone, email, in writing.
- Give names of people with whom you spoke and summaries of your conversations.
- Provide written documents issued by the Claims Administrator.

Submit important documentation with your appeal

- Letter from your treating physician giving the medical reasons that support why the requested service should be approved
- Notes from your treating physician that give information on the medical care provided to you including how you responded to treatment
- Results of any relevant tests or procedures related to the requested service

Research the procedure

- Determine exactly what the procedure was.
- Search for examples where claims for that same procedure were paid.
- Include current medical literature or studies documenting the medical effectiveness of the requested services for experimental or Investigational treatments.
- Provide peer-reviewed articles from your physician's professional journals or magazines that support the recommended treatment.

2. Look for a Response from Claims Administrator

Letter from the Claims Administrator

- Within 10 business days: letter that acknowledges receipt of your request for an appeal
- Within 30 days: letter from Claims Administrator with a final resolution to your request for an appeal

3. How to Respond if Dissatisfied with Claims Administrator's Decision of Your Appeal

Request an independent review of the Claims Administrator's decision by an external review organization

- Denials that involve a medical necessity or experimental/investigative determination, claims subject to the No Surprise Act under the Consolidated Appropriations Act, or if you are appealing a rescission of your policy are eligible for external review.
- Include all of the information from the Level 1 appeal, including the denial letter and updated references related to the unfavorable decision.
- Within 45 days: You will be notified of the external review organization's decision.

4. How to Request an Expedited Review of a Coverage Decision

Your attending physician believes that the Claims Administrator's decision requires a quicker review because a delay could seriously harm your life, health, or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment you are seeking.

The Claims Administrator will review your request and notify you and your physician of their decision no later than 72 hours after receiving the request.

How to Designate a Representative to Act on Your Behalf

- Contact Claims Administrator for an *Appointment of Representation* form.
- Allow Claims Administrator to discuss your appeal with your designated representative.

16. Disputing a Preliminary Claim Review or Claim Payment Denial

C. Independent Review Organization (IRO) 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. Denials that involve a medical necessity or experimental/investigative determination, claims subject to the No Surprise Act under the Consolidated Appropriations Act, or if you are appealing a rescission of your policy are eligible for external review. 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 time frame 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.

D. Optional Employee Benefits Review Committee Appeal Process

In certain very limited circumstances, if your claim for benefits under the plan is wholly or partially denied at the level of the IRO and procedural error is involved, 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 in which the final decision is made by the IRO.

Your request must be in writing and received by the Office of Human Resources, University of Minnesota, 100 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 the Office of Human Resources within 30 days of the receipt of your request for review by the Employee Benefits Review Committee.

E. Legal Action

If you have gone through the entire internal claims process, you have the right to file a lawsuit challenging the denial. The claims procedures described above, except the external review, are required by federal law and are designed to ensure that disputes regarding the Plan are decided by the appropriate plan fiduciaries. Therefore, courts almost always require that a claimant exhaust a plan's internal claims procedures before filing suit (both filing the initial claim and appealing a denied claim). If you fail to do so, the court will likely dismiss your lawsuit. You are not required to use external review, but you have the choice to do so. In a lawsuit, the court generally will review a decision on appeal based on the evidence and arguments that were presented. Except in rare circumstances, the court will not allow you to introduce new evidence or arguments to support your claim. Thus, you should make sure that everything that you believe supports your position is submitted to the appropriate plan fiduciaries during the claims process.

You may pursue legal action only after you have completed the internal claims process described above. In addition, if you have completed the internal claims process above and want to bring a lawsuit, you must do so within one year of the final denial of your claim (or the final denial by an Independent Review Organization, if applicable). This time period is tolled during any external appeal process. If you want to bring a lawsuit related to the Plan for any reason other than to claim a benefit, you must do so within one year of the act or omission giving rise to the claim. Failure to file a lawsuit within these time periods will cause your rights to expire.

17. Plan Amendments

The Plan is governed by the laws of the State of Minnesota. All lawsuits arising under the Plan or relating to the Plan must be submitted to the United States District Court for the District of Minnesota. By participating in the Plan, or by asserting an entitlement to any right or benefit under the Plan, you consent to the United States District Court for the District of Minnesota's exercise of personal jurisdiction over you, and you waive any argument that that forum is not a convenient forum in which to resolve the lawsuit.

The University of Minnesota Office of Human Resources 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.

18. Subrogation

Although the Plan has the right to reimbursement and subrogation, the Plan has contracted with the Claims Administrator to manage those rights. 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 that 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.

19. Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get this information.

Please review it carefully.

If your spouse or any dependents are covered by any of your University-sponsored health plans, please share this notice with them. This notice also applies to their dental information.

A. Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You may ask to see or get a copy of your health and claims records and other health information we have about you. Use the contact information at the end of this notice to send a written request to ask us for this information.
- We will provide a copy or a summary of your health and claims records. We may charge a reasonable, cost-based fee. In very limited cases, we may deny your request. If we deny your request, you may request a review of our decision.

Ask us to correct health and claims records

- You may ask us to correct your health and claims records if you think they are incorrect or incomplete. Use the contact information at the end of this notice to send a written request for a correction or update.
- We may say “no” to your request, but if we do, we will provide you a written explanation about our decision.

Request confidential communications

- You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. If you ask us to use a different address, we will use that address for all general University-sponsored health plan communications. Use the contact information at the end of this notice to send a written request or email to ask us to do this.
- We will accommodate reasonable requests if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You may ask us to **not** use or share certain health information for treatment, payment, or our operations. You may also ask us to **not** use or share your information with family members or others involved in your health care or payment for your care. Use the contact information at the end of this notice to send a written request to ask us to do this.
- We will try to accommodate your request, but we are not required to agree to any request.

Get a list of those with whom we have shared information

- You may ask for a list of the times we have shared your health information, with whom we have shared it, and why. You may ask for a specific time period to be covered by the list, but we will not provide any information that goes back more than six years before your request.
- The list will not include any sharing done at your request or for treatment, payment, health care operations, and certain other cases. We will provide one list free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- To get a list send a written request to the address at the end of this notice.

19. Notice of Privacy Practices

Get a copy of this notice

- You may ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. Use the contact information at the end of this notice to submit a written request for a paper copy.
- You may also obtain a copy of this notice on our website at healthprivacy.umn.edu. The notice is in the Medical Summary of Benefits and the Dental Summary of Benefits.

File a complaint if you feel your rights are violated

- You may complain if you feel we have violated your rights. Use the contact information at the end of this notice to make your complaint.
- You may also contact the U.S. Department of Health and Human Services Office for Civil Rights to complain.
- We will not retaliate against you for any complaints you make.

B. Your Choices

For certain health information, you may make choices about what we share. If you have a clear preference for how we share your information in the situations described below, use the contact information at the end of this notice to write us and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious or cannot be located, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we will not share your information unless you give us written permission or we meet certain specific conditions:

- Marketing purposes

The only time we may use or share your information for marketing purposes without your permission is when we have a face-to-face interaction with you, such as talking with you at a University health and benefits fair, or we provide you with a gift of nominal value, such as mailing you a calendar highlighting dates related to your Wellbeing Program or health plan coverage.

- Sale of your information

The only time we may share your information in a sales transaction without your permission is when the sale is specifically permitted under the law, such as the sale of an entire business operation.

- Psychotherapy notes

The only time we may use or share your psychotherapy notes without your permission is when the law requires or specifically permits us to do so, when they are an issue in a legal action brought by you, they are related to treatment, payment or healthcare operations, or certain other limited situations such as oversight of the provider who treated you.

C. Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Help manage the health care treatment you receive

We may use your health information to coordinate your care and share it with professionals who are treating you, but Minnesota law requires that we get your permission before we can do this.

19. Notice of Privacy Practices

Example: A doctor treating you for an injury requests information about your Primary Care providers in order to provide appropriate treatment. Minnesota law requires that we get your written consent before we can share this information.

Run our organization

We may use and disclose your information to run our organization, evaluate and enhance our plans, develop program offerings, and contact you. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

Example: We analyze health data to determine how to improve our services, develop plan rates, perform underwriting, and make decisions about enhancements and modifications for future plans and coverage. We share health information with our Claims Administrators and other organizations called “business associates” who help us manage our plans, develop new services, and assist in performing the treatment, health care operations and payment functions to administer our plans and services. We use health information about you to suggest particular wellbeing or disease management programs that could help improve your health.

Pay for your health services

We may use your health information to coordinate payment for your health care, but Minnesota law requires us to get your permission before we may share your health information to pay for your health services.

Example: Minnesota law requires that we get your written consent before we share information about you in order to facilitate payment for your treatment or coordinate benefits with other plans you may have.

Administer your plan

The University of Minnesota sponsors all of the University health plans. Certain of your health information is shared with people within the University to administer health plans.

Example: We share certain health information within the University such as information needed to explain the premiums we charge, as well as information about enrollment, disenrollment, and summary health information. Under certain circumstances we may share additional health information for plan administration, provided the recipient agrees to handle the information according to applicable law.

How else can we use or share your health information?

We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We may share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Conduct research

We may use or share your information to conduct research and may share your information with outside researchers if you do not object.

19. Notice of Privacy Practices

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner

We may share health information about you with organ procurement organizations. We may share health information with a coroner or medical examiner when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We may use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We may share health information about you in response to a court or administrative order, subpoena, discovery request, or other legal process.

D. Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information, provide you with this notice, and notify you if there is a breach of any of your unsecured health information. We must follow the duties and privacy practices described in this notice. We will not share your health information in any way that is not described in this notice without getting your permission. Unless we have already taken action on your permission, you may take back or revoke your permission at any time by writing to us using the contact information at the end of this notice.

E. Effective Date and Changes to This Notice

The effective date of this notice is January 1, 2023. We may change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our website at z.umn.edu/benefits. The notice is included in the **Medical Summary of Benefits** and **Dental Summary of Benefits**.

This Notice of Privacy Practices applies to health plans sponsored by the University of Minnesota, including:

- Medical Plans, administered by Medica
- Pharmacy Program, administered by Prime Therapeutics and Fairview Specialty Pharmacy
- Medication Therapy Management, administered by the Medica and Network Pharmacies
- Dental Plans, administered by Delta Dental
- Health Care Flexible Spending Accounts, administered by WEX
- Emergency Travel Assistance Program, administered by Redpoint
- Wellbeing Program, administered by Virgin Pulse, Medica, and the University of Minnesota
- University of Minnesota Employee Assistance Program (EAP), provided by the University of Minnesota and Lyra Health

F. Contact Information

University of Minnesota
Health Information Privacy & Compliance Office
MMC 501
420 Delaware Street SE
Minneapolis, MN 55455
privacy@umn.edu
612.624.7447

20. Notice About the University of Minnesota Wellbeing Program

The University of Minnesota Wellbeing Program is a voluntary Wellbeing Program available to all employees who participate in the University of Minnesota Medical Program. The program is administered according to federal rules permitting employer-sponsored wellbeing 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 Wellbeing Program you can choose to complete a health assessment, which asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (for example, 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 health assessment or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the Wellbeing Program can qualify for an incentive of a \$500 or \$750 reduction in Medical Program rates (depending on the level of medical coverage they have elected).

If you are unable to participate in any of the health-related activities, you may be entitled to a reasonable accommodation. You may request a reasonable accommodation by contacting the OHR Contact Center at well@umn.edu, 612-624-8647, or 1-800-736-2363. The incentive is available to employees who complete a number of wellbeing-related activities that qualify them to earn 5,000 or 7,500 wellbeing points, and the resulting reduction in rates. Although you are not required to complete the health assessment or participate in the biometric screening, you may choose to do so to help earn your incentive.

The information from your health assessment and biometric screening will help you understand your current health and potential risks and may also be used to offer you coaching services through the Wellbeing 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 Wellbeing 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 Wellbeing 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 to participate in the Wellbeing Program or as expressly permitted by law.

Medical information from the Wellbeing Program that personally identifies you will not be provided to your supervisors or managers and may never be used to make decisions about your employment.

20. Notice About the University of Minnesota Wellbeing 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 of the Wellbeing Program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the Wellbeing Program or receiving an incentive.

Anyone who receives your information to provide you with Wellbeing Program services will abide by the same confidentiality requirements. The only people who will receive your personally identifiable health information are a health coach, a registered nurse, or a Medication Therapy Management pharmacist, in order to provide you with services under the Wellbeing Program.

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

Appropriate precautions will be taken to avoid any data breach. Should a Wellbeing Program data breach occur, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide to the Wellbeing Program, nor may you be subjected to retaliation if you choose not to participate.

B. Contact Information

If you have questions or concerns about this notice, or about protections against discrimination and retaliation, call the OHR Contact Center at 612-624-8647 or 1-800-736-2363.

21. COBRA Notice

This notice contains important information about your right to COBRA continuation coverage—a temporary extension of benefit coverage under the Plan that can become available to you and other eligible members of your family if you 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 benefits plan, 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 Plan 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 Plan 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 Plan 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 Plan due to one of the following qualifying events:
 - a) Your hours of employment are reduced below a 50% to 74% time appointment
 - 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 Plan 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)
 - e) Employee divorces

21. COBRA Notice

3. Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan 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)
 - 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
 - f) Employee is divorced

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Office of Human Resources 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 or date of the COBRA notice, whichever is later, to elect COBRA continuation coverage.

Note: For other qualifying events—divorce, legal separation, or a dependent child losing eligibility for coverage—you must notify the Office of Human Resources within 60 days after the qualifying event occurs. You must either send a letter of notification to: 100 Donhowe Building, 319 15th Avenue SE, Minneapolis, MN 55455; or call the Office of Human Resources Contact Center at 612-624-8647 or 800-756-2363. The Office of Human Resources will send you the appropriate form to complete. This form must then be completed and sent to 121 Benefits at the address above, and postmarked within the 60-day time limit.

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 or date of the COBRA notice, whichever is later, to elect COBRA continuation coverage.

Once the Office of Human Resources notifies the Plan 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 Plan 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 ended had this event not occurred.

When the qualifying event is a dependent child losing eligibility, legal separation, or death, 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 now covered under the Plan 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 the Office of Human Resources 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
- 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 University COBRA Administrator. If you fail to notify the Office of Human Resources 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 the Office of Human Resources 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), or is divorced. The extension is also available to a dependent child who is no longer eligible under the Plan as a dependent child. In all these cases, you must make sure that the Office of Human Resources is notified in writing within **60 days** of the second qualifying event. This notice must be sent to the Plan COBRA Administrator.

If you fail to notify the Office of Human Resources 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 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 the Office of Human Resources 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 the Office of Human Resources of the date of your Medicare entitlement.

C. End of COBRA Continuation Coverage

Your COBRA continuation coverage may be terminated before 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 promptly.

21. COBRA Notice

Note: You will have 45 days from the date you elect COBRA continuation coverage to make your first premium payment to the University 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 of January 31.

Payments made after the 30-day grace period will be returned to you and all coverage will be canceled 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

To protect the rights of you and your family, you should keep the Office of Human Resources 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 the Office of Human Resources or to the University COBRA Administrator.

F. Questions About Billing

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

1. University COBRA Administrator—Medical, Dental and Life Insurance:

For billing questions about medical or dental benefits or life insurance coverages, the University COBRA Administrator is:

Benefit Resource
PO Box 850
Omaha NE 68103-3850
Phone 866-996-5200
participantservices@benefitresource.com

2. University COBRA Administrator—Flexible Spending Account: For billing questions about the flexible spending account, call:

OHR Contact Center
612-624-8647 or 800-756-2363

G. Questions About Coverage

If you have questions about your COBRA coverage, call 612-624-8647 or 800-756-2363 to reach the OHR Contact 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.

22. Important Notice From the University of Minnesota About 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 everyone with prescription drug coverage who is eligible for Medicare. In addition, the University sends this notice to people who are approaching Medicare eligibility. This notice can also be found in the Medical Summary of Benefits. Medicare entitlement includes those who qualify for Medicare because of a disability or end-stage renal disease, as well as people over age 65.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the University of Minnesota's Medical Program for employees, early retirees, disabled, and COBRA participants (and dependents) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare 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 employee Medical Program is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing employee Medical coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current employee Medical Program coverage will not be affected. Your current employee Medical Program coverage will be the secondary coverage, and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current employee Medical Program prescription drug coverage for retirees over age 65, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

22. Important Notice From the University of Minnesota About Your Prescription Drug Coverage and Medicare (continued)

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

For More Information About This Notice or Your Current Prescription Drug Coverage

Call 612-624-8647 or 800-756-2363 to reach the University of Minnesota Office of Human Resources Contact Center.

NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through the Employee Medical Program changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

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

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

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

Date: September 2022

Sender: University of Minnesota Office of Human Resources

Contact: Office of Human Resources Contact Center

Address: 319 15th Avenue SE
Minneapolis, MN 55455-0103

Phone: 612-624-8647 or 1-800-756-2363

23. Children’s Health Insurance Program (CHIP) Notice

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, 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, contact your state Medicaid or CHIP office or dial 1-877-KIDS NOW or visit www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your state for more information on eligibility:

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

ALABAMA - Medicaid

Website: <http://myalhipp.com/>

Phone: 1-855-692-5447

ALASKA - Medicaid

The AK Health Insurance Premium Payment Program

Website: <http://myakhipp.com/>

Phone: 1-866-251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility: <http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

ARKANSAS - Medicaid

Website: <http://myarhipp.com/>

Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - Medicaid

Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx

Phone: 916-440-5676

COLORADO - Health First Colorado (Colorado's Medicaid Program) and Child Health Plan Plus (CHP+)

Health First Colorado Website:

<https://www.healthfirstcolorado.com/>

Health First Colorado Member Contact Center:

1-800-221-3943/ State Relay 711

CHP+: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>

CHP+ Customer Service: 1-800-359-1991/ State Relay 711

Health Insurance Buy-In Program (HIBI): <https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program>

HIBI Customer Service: 1-855-692-6442

FLORIDA - Medicaid

Website: <https://www.flmedicaidmanagedcare.com/>

Phone: 1-877-357-3268

GEORGIA - Medicaid

Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>

Phone: 678-564-1162 ext 2131

INDIANA - Medicaid

Healthy Indiana Plan for low-income adults 19-64

Website: <http://www.in.gov/fssa/hip/>

Phone: 1-877-438-4479

All other Medicaid

Website: <https://www.in.gov/medicaid/>

Phone 1-800-457-4584

IOWA - Medicaid and CHIP (Hawki)

Medicaid Website: <https://dhs.iowa.gov/ime/members>

Medicaid Phone: 1-800-338-8366

Hawki Website: <http://dhs.iowa.gov/Hawki>

Hawki Phone: 1-800-257-8563

KANSAS - Medicaid

Website: www.kdhe.ks.gov/250/About-Medicaid-CHIP

Phone: 1-800-792-4884

KENTUCKY - Medicaid

Kentucky Integrated Health Insurance Premium Payment

Program (KI-HIPP) Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>

Phone: 1-855-459-6328

Phone: 1-855-459-6328

Email: KIHIP.PROGRAM@ky.gov

KCHIP Website: <https://www.kdhe.ks.gov/250/About-Medicaid-CHIP>

Phone: 1-877-524-4718

Kentucky Medicaid Website: <https://chfs.ky.gov>

LOUISIANA - Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488

(LaHIPP)

MAINE - Medicaid

Enrollment Website: <https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 1-800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium Webpage:

<https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 1-800-977-6740.

TTY: Maine relay 711

MASSACHUSETTS - Medicaid and CHIP

Website: <http://www.mass.gov/eohhs/gov/departments/masshealth/>

Phone: 1-800-862-4840

MINNESOTA - Medicaid

Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>

Phone: 1-800-657-3739

MISSOURI - Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 573-751-2005

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) *continued*

MONTANA - Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084

NEBRASKA - Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA - Medicaid

Medicaid Website: <http://dhcfnv.gov>

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>

Phone: 603-271-5218

Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY - Medicaid and CHIP

Medicaid Website:

<https://www.nj.gov/humanservices/dmahs/clients/medicaid/index.html>

Medicaid Phone: 609-631-2392

CHIP Website: <http://www.njfamilycare.org/default.aspx>

CHIP Phone: 1-800-701-0710

NEW YORK - Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA - Medicaid

Website: <https://medicaid.ncdhhs.gov/>

Phone: 919-855-4100

NORTH DAKOTA - Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>

Phone: 1-844-854-4825

OKLAHOMA - Medicaid and CHIP

Website: <http://www.insureoklahoma.org>

Phone: 1-888-365-3742

OREGON - Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>

<http://www.oregonhealthcare.gov/index-es.html>

Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid

Website: <https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>

Phone: 1-800-692-7462

RHODE ISLAND - Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>

Phone: 1-855-697-4347, or 401-462-0311 (Direct RItte Share Line)

SOUTH CAROLINA - Medicaid

Website: <https://www.scdhhs.gov>

Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: <https://dss.sd.gov/>

Phone: 1-888-828-0059

TEXAS - Medicaid

Website: <http://gethipptexas.com/>

Phone: 1-800-440-0493

UTAH - Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov/>

CHIP Website: <http://health.utah.gov/chip>

Phone: 1-877-543-7669

VERMONT- Medicaid

Website: <http://www.greenmountaincare.org/>

Phone: 1-800-250-8427

VIRGINIA - Medicaid and CHIP

Website: <https://www.coverva.org/hipp/>

Medicaid Phone: 1-800-432-5924

CHIP Phone: 1-855-242-8282

WASHINGTON - Medicaid

Website: <https://www.hca.wa.gov/>

Phone: 1-800-562-3022

WEST VIRGINIA - Medicaid

Website: <http://mywvhipp.com/>

Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>

Phone: 1-800-362-3002

WYOMING - Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>

Phone: 1-800-251-1269

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) *continued*

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The department notes that a federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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24. 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 OHR Contact 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 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.

This publication/material is available in alternative formats upon request. Please contact Nora Hayes, Office of Human Resources, nhayes@umn.edu or 612-624-8678.



Office of Human Resources

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BENEFIT QUESTIONS

You can reach the Office of Human Resources (OHR) Contact Center at 612-624-8647 or 1-800-756-2363, select option 1, or email benefits@umn.edu.



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