UNIVERSITY OF NEW HAMPSHIRE

STUDENT HEALTH BENEFITS PLAN (SHBP)
PLAN DOCUMENT

Revised Effective: August 23, 2013
Originally Effective August 1, 2007

For the most current information regarding the SHBP, refer to the SHBP website at: www.UNH.edu/SHBP

Table of Contents

Table of Contents

Table of Contents

NOTE: Abbreviations and terms both capitalized and italicized are defined in Section XVIII: Definitions (e.g., *Urgent Care*). Capitalized terms without italics are either major or subsection headings in this Plan Document or are terms used to identify organizations or individuals in Section III: General Information (e.g., Claims Administrator, Plan Administrator). For capitalized terms without italics with no specific section referral, see the Table of Contents and/or Section III: General Information.

THIS INSTRUMENT, established by the University of New Hampshire (hereinafter UNH or Plan Sponsor), sets forth the University of New Hampshire Student Health Benefits Plan (hereinafter the SHBP).

A. Establishment of the SHBP. UNH hereby sets forth its student group health plan under the following terms and conditions.

(1) UNH provides the SHBP for the sole purpose of providing health care benefits to the *Students* covered by the program. SHBP reserve funds are encumbered for the sole purpose of operating the SHBP.

(2) In the event there are surplus reserve funds upon termination of the SHBP, these funds will be used exclusively to provide health care services and/or health education services for the UNH *Student* population.

(3) SHBP claims/operating funds and SHBP reserve funds earn interest income and are not commingled with other UNH accounts.

(4) Benefits are administered exclusively based on the provisions of this Plan Document. There are no unpublished Plan provisions. Refer to www.unh.edu/shbp for all documents pertaining to the program and/or links to other applicable UNH policies.

(5) Extra-contractual benefits may be provided only to the extent that the Plan Administrator determines that such benefits are *Medically Necessary* and result in either (1) improved quality of care for the *Covered Person* with no substantive difference in the amount of benefit payments that would otherwise be provided by the SHBP, or (2) cost savings for the SHBP. Upon recommendation of the Claims Administrator, any extra-contractual benefits must be reviewed and approved by the Plan Administrator.

B. Effective. The SHBP for the 2013-14 *Plan Year*, as described herein, is revised effective **August 23, 2013**, originally effective August 1, 2007.

C. General Provisions. The SHBP is subject to all of the conditions and provisions set forth in this document and subsequent amendments, which are made a part of this Plan Document.

IN WITNESS WHEREOF, the University of New Hampshire has caused the SHBP to be executed by its duly-authorized representative.

University of New Hampshire

_____	By:	_____
Date		Authorized Signature
_____		_____
Title		Printed Name

The University of New Hampshire (UNH) has prepared this document to help you understand your medical and prescription drug benefits as a *Covered Person* in the Student Health Benefits Plan (SHBP). Please read it carefully. The Schedule of Benefits provides an overview of your coverage.

Abbreviations and terms both capitalized and italicized are defined in Section XVIII: Definitions (e.g., *Urgent Care*). Capitalized terms without italics are either major or subsection headings in this Plan Document or are terms used to identify organizations or individuals in Section III: General Information (e.g., Claims Administrator, Plan Administrator). For capitalized terms without italics with no specific section referral, see the Table of Contents and/or Section III: General Information.

For United States citizens and permanent residents, treatment or services rendered outside the United States of America or its territories are covered on the same basis as treatment or services rendered within the United States. For international *Student*s and their covered dependents, such SHBP benefits are provided only to the extent that they are not covered by any other insurance plan, insurance program, or system of socialized medicine.

Your benefits under the SHBP are affected by certain limitations and conditions designed to encourage you to be a wise consumer of health services and to use only those services you need. Also, benefits are not provided for certain kinds of treatments or services, even if your health care *Provider* recommends them.

You can minimize your out-of-pocket expenses by using *In-Network Providers*. We also encourage you to use the Counseling Center and Health Services at UNH whenever possible, including the after-hours services provided by Wentworth-Douglass Hospital. More information about the Counseling Center may be obtained from its website at www.uhcc.unh.edu. The Health Services website is www.unh.edu/health-services.

If you have questions about any of your coverage, please contact the SHBP's Claims Administrator: Consolidated Health Plans, 800-633-7867. By working together, we can help contain medical expenses. Please make note of the following provisions.

(1) Preferred Provider Networks

The chosen Preferred Provider Network is a group of *Providers*/*Practitioners* and *Hospitals* who have agreed to accept a negotiated fee for their services. Preferred Provider Networks may be used by *Covered Persons* to provide most of the Covered Medical Services described in Section VII of this Plan Document. As a *Covered Person* in the SHBP, you maintain the freedom to choose participating or non-participating *Provider*s/*Practitioners*. Please visit www.mycignaforhealth.com for a listing of participating *Provider*s/*Practitioners*.

When you choose a participating *Provider*/*Practitioner* or *Hospital*, the SHBP contains many advantages because:

(a) you usually pay less out-of-pocket for health care services;

(b) you may change your *Provider(s)/Practitioner(s)* and/or *Hospital* at any time, because you are not required to designate a primary care *Provider/ Practitioner*;

(c) your participating *Provider(s)/Practitioner(s)* and/or *Hospital* will file claims directly, so you do not have to wait for claim reimbursement; and

(d) you are not responsible for charges over the negotiated fees allowed by the applicable network for the Covered Medical Services described under Section VII of this Plan Document, but you are responsible for the applicable deductible, copayment, and/or coinsurance amounts.

Please also refer to the important Preadmission/Precertification of care requirements, explained in Section VIII.

(2) Outpatient surgery

If appropriate, consider having surgery performed in the outpatient department of the *Hospital*, a surgical care center, or a *Provider's/Practitioner's* office. This will eliminate the *Hospital* room and board charges as well as overnight stays.

(3) Generic Medications

A generic drug is a prescription drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. Whenever possible, request that your *Provider(s)/Practitioner(s)* prescribe a generic drug if it is the lowest cost option.

(4) Patient and Protection Affordable Care Act (PPACA)

Effective for the 2013-14 plan year, UNH has configured the SHBP to voluntarily comply with the benefit requirements, appeals procedures, and certain other provisions of the regulations issued by the U.S. Department of Health and Human Services for fully insured student health insurance programs under the Patient Protection and Affordable Care Act (PPACA). You are encouraged to review the preventive care benefits included in the program and the new appeals procedure. Refer respectively to Sections VI: PPACA Preventive Care Benefits, and Section XIX-B: Inquiry, Grievance, and Appeals Process.

Plan Name	University of New Hampshire Student Health Benefits Plan (SHBP).
Type of Plan	Non-ERISA governed student health benefits plan providing medical and prescription drug benefits on a partially self-funded basis.
Effective	**Revised effective August 23, 2013;** **Originally effective August 1, 2007.**
Plan Sponsor	University of New Hampshire Health Services 12 Ballard Street Durham, NH 03824 (603) 862-2853
Group Number	S210112
Plan Administrator	Director of Finance and Administration Health Services University of New Hampshire 12 Ballard Street Durham, NH 03824 (603) 862-2853 www.unh.edu/shbp healthservices@unh.edu
Claims Administrator (refer to Section XIX, Procedures/Statement of Rights, for claims submission instructions)	Consolidated Health Plans, Inc. 2077 Roosevelt Ave. Springfield, MA 01104 www.consolidatedhealthplan.com (800) 633-7867
In-Network Providers	CIGNA www.mycignaforhealth.com
Prescription Benefit Administrator	University of New Hampshire Health Services Pharmacy 12 Ballard Street Durham, NH 03824
Case Management Services	CIGNA (800) 633-7867
Medical Evacuation and	FrontierMEDEX

Repatriation Provider	North America: 800-527-0218 Foreign Countries: 410-453-6330 (collect calls)
Agent for Service of Legal Process	Ronald F. Rodgers General Counsel University of New Hampshire Myers Center 2700 Concord Road Durham, NH 03824 (603) 862-0960 FAX: (603) 862-0909
Termination and/or Modification of SHBP	The Plan Sponsor may terminate the SHBP at the end of any *Plan Year*, or change the provisions of the SHBP at any time by a written Plan Document amendment signed by a duly-authorized officer of the Plan Sponsor. The consent of any *Covered Person* is not required to terminate or change the SHBP.

NOTE: The SHBP is not an employer-sponsored health plan. Accordingly, the rules and regulations of the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1996 (COBRA), and other federal laws that apply exclusively to employer-sponsored health plans are not applicable to the SHBP. To the extent that the SHBP voluntarily adopts certain practices as described under ERISA, such adoption shall not be deemed to subject the SHBP to ERISA regulation. Similarly, as a partially self-funded health plan, the SHBP is not regulated by the State of New Hampshire's Department of Insurance.

The federal laws and regulations that are applicable to the SHBP include, but are not limited to, the following.

- Title IX of the Education Amendments of 1972. The SHBP provides pregnancy benefits on the same basis as any other temporary disability.
- Section 504 of the Rehabilitation Act of 1973.
- Age Discrimination Act of 1975.
- Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Regulations of the United States Information Agency applicable to visa recipients.

For the 2013-14 *Plan Year*, UNH is voluntarily complying with the benefit requirements mandated in regulations for fully insured student health insurance plans issued by the U.S. Department of Health and Human Services (refer to Federal Register 77 FR 16453).

It is the policy of UNH to uphold the constitutional rights of all members of the University community and to abide by all United States and New Hampshire State laws and University System of New Hampshire and UNH policies applicable to discrimination and harassment. In accordance with those laws and policies, all members of the UNH community will be responsible for maintaining a university environment that is free of discrimination and harassment based on race, color, religion, sex, age, national origin, sexual orientation, gender identity or expression, disability,

veteran status, or marital status. Therefore, no member of UNH may engage in discriminatory or harassing behavior within the jurisdiction of the university that unjustly interferes with any individual's required tasks, career opportunities, learning, or participation in university life.

Full disclosure of UNH's Affirmative Action and Equity Policy may be found online at http://usnholpm.unh.edu/UNH/V.Pers/B.htm#5.

A. Eligible Students

Students eligible for the SHBP are defined as:

(1) any full-time domestic undergraduate degree candidate *Student* (12 or more credits per semester);

(2) full-time exchange students enrolled at UNH (12 or more credit hours per semester);

(3) any full-time domestic graduate degree candidate *Student* (9 credits or more per semester);

(4) any *Student* enrolled in a post-baccalaureate certificate program (9 or more credits per semester);

(5) any *Student* enrolled in Doctoral Research 999 or GRAD 900;

(6) any undergraduate or graduate *Student* holding an F-1 or J-1 visa (regardless of the number of credit hours or degree candidate status);

(7) any Graduate Assistant or Fellow;

(8) any part-time undergraduate or graduate *Student* (fewer than 9 credits per semester), but eligibility is limited to the spring semester and only if the *Student* had been enrolled in the SHBP in the previous fall semester and is in the last semester of his/her educational program;

(9) *Student*s (a) who otherwise meet the eligibility requirements specified in this Section, (b) were covered by the SHBP in the *Coverage Period* immediately preceding the period for which this eligibility provision applies, and (c) who are enrolled in a UNH program that has a *Coverage Period* that differs from the semester or summer session *Coverage Period*s specified in the SHBP brochure (coverage will be provided on a pro-rated monthly basis for this class of eligible *Student*s); or

(10) other classes of *Students* determined by UNH to be eligible for the SHBP, and officially published by amendment to this Plan Document, as being eligible for the SHBP.

Any *Student* who does not meet one of the classifications listed above is not eligible to enroll in the SHBP. Except as provided in the Continuation of Coverage provision, a *Student* must maintain eligibility for the SHBP for the first thirty-one (31) calendar days of the semester that he or she first enrolls in the SHBP. *Student*s who do not meet this requirement are not eligible for participation in the SHBP.

Eligible *Students* may choose to participate in the SHBP during the *Annual Open Enrollment Period* with coverage commencing on the first day of the *Plan Year* or the first day

of the *Coverage Period* (the *Effective Date*). The *Effective Date* will be earlier than the first day of the *Plan Year* if the *Student* is required by UNH to be on campus or participate in a UNH-sponsored activity or program. In no event will the *Effective Date* be more than twenty (20) days earlier than the first day of the *Plan Year*.

The requirements for *Students* to have health insurance are established by UNH under policies published separately from this Plan Document.

Eligible *Students* must enroll each *Plan Year* by the enrollment deadlines established by the Plan Administrator. *Students* who have other health insurance will be able to waive coverage under the SHBP if their insurance meets or exceeds the waiver criteria established and published by the Plan Administrator. All waivers must be received by the Plan Administrator by the due dates established and published by the Plan Administrator each *Plan Year*. Otherwise, eligible *Students* will be automatically enrolled in and charged for the SHBP.

Each *Student* who meets the eligibility requirements of the SHBP and who submits an enrollment application that has been approved by the Plan Administrator (or who is automatically enrolled per the terms of the SHBP) shall become a *Covered Student*.

A SHBP-*Covered Student* who withdraws from UNH during any *Coverage Period* will not lose eligibility for the SHBP, providing that no portion of his or her tuition/fees is eligible to be refunded by the University. Coverage will remain in force, including coverage for any dependents covered by the SHBP, for the remainder of that *Coverage Period*. Refunds for the cost of coverage under the SHBP are provided only to *Students* who enter into the *Uniformed Services*.

B. Qualified Late Enrollees

Students may be approved to enroll in the SHBP after the *Plan Year's* enrollment deadline under the provision established in this Section. Eligible *Students* may include those who enroll at UNH in the spring semester, or those who *Involuntarily Lose* eligibility under a group health insurance plan either due to a loss of employment or to attainment of a maximum age to be covered under their parent's plan. Such *Students* will be Qualified Late Enrollees for the SHBP if they request enrollment from the Plan Administrator within thirty (30) days of the *Involuntary Loss* of their group health insurance plan, or within the enrollment deadlines for spring semester *Students* as established by the Plan Administrator. Qualified Late Enrollees may also enroll their *Eligible Dependents* in the SHBP. Documentation of *Involuntary Loss* of coverage must be provided to the Plan Administrator. The cost of the SHBP is pro-rated for Qualified Late Enrollees on a monthly basis. The *Effective Date* will be the first of the month in which the *Student Involuntarily Loses* his or her health insurance.

Qualified Late Enrollees also includes any eligible student who is discovered to be without health insurance and who has not yet attained age 19.

C. Unqualified Late Enrollees

Any eligible *Student* who is subject to the University of New Hampshire's insurance requirement and is found to be uninsured during the *Plan Year* (and is not a Qualified Late Enrollee) will be required to enroll in the SHBP. Unqualified Late Enrollees cannot purchase dependent coverage under the SHBP until the next *Annual Open Enrollment Period*.

Unqualified Late Enrollees will be subject to a pre-existing condition limitation (as specified under Section X(B), Pre-existing Condition Limitation) that includes a six-month look-back period for diagnosis or treatment and a six-month waiting period for benefits for any pre-existing condition to begin. The cost of the SHBP is not pro-rated for Unqualified Late Enrollees.

D. Eligible Dependents

An *Eligible Dependent* is one of the following:

(1) A person of the opposite gender who is the husband or wife of the *Covered Student*. Such person may also be referred to as a spouse under the terms of the SHBP.

(2) A child of the *Covered Student* who has not attained the age of 26 and who meets the following requirements is an *Eligible Dependent*:

- a natural child;
- a stepchild by legal marriage;
- a child who has been legally adopted by the *Covered Student* or placed with the *Covered Student* for adoption by a court of competent jurisdiction; or
- a child for whom legal guardianship has been awarded, provided that the child legally resides with the *Covered Student* in a parent-child relationship for more than one-half of the taxable year, must not have provided more than one-half of his or her own support in that year, or be the subject of a Qualified Medical Child Support Order (as described later in this section).

(3) A child who meets any of the requirements in (a) through (d) above and who is permanently and *Totally Disabled* (as defined in Internal Revenue Code Section 22(e)(B)) at any time during the calendar year in which the *Covered Student* begins coverage is an *Eligible Dependent*. The Plan Administrator may require, at reasonable intervals during the two years following the child's 26th birthday, subsequent proof of the child's incapacity and dependency. After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator has the right to have such child examined by a *Provider*/*Practitioner* of the Plan Administrator's choice to determine the existence of such incapacity.

(4) A same-sex domestic partner is an *Eligible Dependent*. In order to obtain SHBP coverage for a same-sex domestic partner, the *Covered Student* must file an Affidavit of Domestic Partnership (Spousal Equivalency) with the Plan Administrator and declare and acknowledge that the *Covered Student* and his/her same-sex domestic partner meet the following criteria:

- they are at least 18 years of age and mentally competent to consent to the contract:
- they are not related by blood to a degree of closeness which would prohibit legal marriage in the state in which they legally reside:
- they reside together in the same residence and intend to do so indefinitely;
- they are jointly responsible for each other's common welfare and financial obligations;
- neither person is married to another person under the laws of the state in which they reside; and
- the two parties are each other's sole same-sex domestic partner and intend to remain so indefinitely.

It is further understood, acknowledged, and agreed that:

- The *Covered Student* shall provide the Plan Administrator with a valid copy of registration of domestic partnership (if any), that may be of record and filed with the partner's city, county, or other municipal registry.
- The *Covered Student* shall immediately notify the Plan Administrator of any changes in the status of his or her same-sex domestic partnership. The *Student* must file a Statement of Domestic Partner Termination with the Plan Administrator within thirty (30) days of the earlier of: (1) the death of the domestic partner; or (2) the date of termination of the domestic partnership.
- The *Covered Student* will be financially liable for the reimbursement of any *Expenses Incurred* as a result of any false or misleading statements contained in the aforementioned Affidavit or accompanying written documentation.
- Any coverage afforded the same-sex domestic partner will be in consideration of said Affidavit and accompanying written documentation being true, complete, and accurate. The same-sex domestic partner shall not be considered for coverage until said Affidavit and accompanying written

documentation is completed, returned, and found to be satisfactory to the Plan Administrator.

- The Affidavit and accompanying written documentation will be maintained by the Plan Administrator as a confidential personal document and shall not be disclosed in the absence of a written consent, except as necessary to provide benefits or as otherwise required by law.

(5) Children of a same-sex domestic partner are *Eligible Dependents*.

If husband and wife (or both same-sex domestic partners) are both *Covered Students*, each can be covered individually or as the *Eligible Dependent* of the other. Neither can be covered both as a *Covered Student* and as an *Eligible Dependent*. Only one of the two covered spouses/partners may cover *Eligible Dependents*.

Except as provided under Subsection B: Qualified Late Enrollees and Subsection C: Unqualified Late Enrollees of this Section IV, each *Eligible Dependent* will be eligible to participate in the SHBP beginning with the latest of the following dates, provided the Plan Administrator is notified in writing within thirty-one (31) days of such event and the *Covered Student* has agreed to pay any required contribution for such coverage:

- the date the *Covered Student's* coverage begins, provided the *Covered Student* enrolled all *Eligible Dependents* on or before the date on which such *Covered Student's* participation commenced hereunder;

- the date of enrollment, if the *Covered Student* enrolls all *Eligible Dependents* within thirty-one (31) days of the *Covered Student's* own eligibility date;

- the date the *Covered Student* enrolls the *Eligible Dependent*, if the enrollment is within thirty-one (31) days of the date any new *Eligible Dependent* is acquired and proof of *Eligible Dependent* status is furnished (A newborn *Eligible Dependent*, born to either a male or female *Covered Student*, is not considered to be acquired until the *Eligible Dependent's* birth.); or

- in the case of an adopted child, the date the child is placed with the *Covered Student* for adoption by a court of competent jurisdiction, as defined in Subsection E of this Section IV.

E. Adopted Child Provision

Eligible Dependent children placed for adoption with a *Covered Student* shall be eligible for coverage under the same terms and conditions as *Eligible Dependent* children who are natural children of *Covered Students*, whether or not the adoption has become final. Coverage under the SHBP shall not be restricted for any *Eligible Dependent* child adopted by the *Covered Student* or placed with a *Covered Student* for adoption if the adoption or placement for adoption occurs while the *Covered Student* is enrolled in the SHBP.

In connection with any adoption, or placement for adoption of a child, the term "child" as used in this Section only means a person who has not attained age eighteen (18) as of the date of such adoption or placement for adoption. The terms "placement" or "being placed for adoption" with any person means: the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

The child's placement for adoption terminates upon the termination of such legal obligations. In such an event, the child's coverage shall cease after the last day of the month the placement is terminated unless coverage must be continued pursuant to a Qualified Medical Child Support Order.

F. Coverage Pursuant to a Qualified Medical Child Support Order

Certain *Eligible Dependents* shall be provided benefits in accordance with applicable requirements of any Qualified Medical Child Support Order, provided that such order does not require the SHBP to provide any type or form of benefit, or any option under the SHBP, not otherwise provided under the SHBP, except to the extent necessary to meet the requirements of law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 4301 of the Omnibus Budget Reconciliation Act of 1993). A *Covered Student* may obtain a copy of the Qualified Medical Child Support Order procedures from the Plan Administrator.

An Alternate Recipient shall mean: any child of a *Covered Student* who is recognized under a Medical Child Support Order as having a right to enroll under the SHBP with respect to such *Covered Person*.

Any payment of benefits made by the SHBP pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian. The terms "Qualified Medical Child Support Order" and "Medical Child Support Order" are defined in Section 609 of ERISA.

PRESCRIPTION BENEFIT	PRESCRIPTION BENEFIT AT UNH HEALTH SERVICES	PRESCRIPTION BENEFIT OUTSIDE OF UNH HEALTH SERVICES
Copayments	The UNH Health Services Pharmacy is the only *Provider* for the following benefit.* UNH Health Services prescription copayments are: **Generic**: $15 (up to a 30-day supply); $0 for generic contraceptive medications or *Medically Necessary* brand contraceptive medications. **Preferred Brand**: $25 (up to a 30-day supply) **Non-Preferred Brand**: $40 (up to a 30-day supply) Note: up to a 90-day supply is available only for winter and summer breaks or for SHBP-*Covered Persons* enrolled at the Manchester campus. In these circumstances, UNH Health Services prescription copays are charged for each 30-day supply of a medication. This benefit is administered internally by UNH, and not by the Claims Administrator.	Coverage for prescriptions outside of UNH Health Services is available only if: (a) the *Covered Person* is not eligible to use UNH Health Services Pharmacy; (b) an urgent or *Emergency* situation is present; (c) the medication is not available through UNH Health Services Pharmacy; or (d) the *Covered Person* incurs treatment for a new medical condition and needs a new prescription while outside of the *Durham Area*. Note: In these situations, a prescription filled at a retail pharmacy will be eligible for coverage under the terms and conditions of Section IX of this Plan Document entitled "Prescription Benefits and Exclusions,' and will be subject to the annual *Plan Year* deductible (shown below) and 20% coinsurance.
Annual Out-Of-Pocket Expense Limit	Outpatient prescription drug copayments/coinsurance do not count toward satisfaction of the Annual Out-of-Pocket Maximum Expense Limit.	

* This applies to *Students* of both the Durham and Manchester campuses.

MEDICAL BENEFITS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Lifetime Maximum	Unlimited	Unlimited
Annual Plan Year Deductible	Not Applicable – In-network benefits are generally subject to a copayment for each service provided.	Per *Covered Person*: $250 Family: $1,000
Coinsurance	Following satisfaction of any required copayment, the SHBP reimburses *Covered Expenses* at 85% of the fee schedule amount (unless otherwise stated) up to the Annual Out-of-Pocket Maximum Expense Limit. The SHBP provides 100% coverage for *Covered Expenses* once your annual out-of-pocket expense maximum is reached.	Following satisfaction of the annual *Plan Year* deductible, the SHBP reimburses *Covered Expenses* up to 80% of *Reasonable and Customary Charges*. The SHBP provides 100% coverage for *Reasonable and Customary Charges* for *Covered Expenses* once your annual out-of-pocket expense maximum is reached.
Annual Out-of-Pocket Maximums (Including the *Plan Year* deductible) Note: Eligible charges incurred for either *In-Network* or *Out-of-Network Providers/Practitioners* will be used to satisfy the Out-of-Pocket Maximums simultaneously.	$3,500 per *Covered Person*, per *Plan Year*. In-Network outpatient prescription drug copayments do not count toward satisfaction of the Annual In-Network Out-of-Pocket Maximum Expense Limit.	$7,000 per *Covered Person*, per *Plan Year*. Out-of-Network deductibles, copayments, and coinsurance count toward satisfaction of the Annual Out-of-Pocket Maximum. In-Network outpatient prescription drug copayments do not count toward satisfaction of the Annual Out-of-Network Out-of-Pocket Maximum Expense Limit.

MEDICAL BENEFITS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Preventive Care Preventive care services are covered in compliance with the Patient Protection and Affordable Care Act (PPACA) for (1) any covered services that are not available at UNH Health Services or (2) for services provided when the SHBP *Covered Person* is away from the *Durham Area*. These limitations do not apply to SHBP *Covered Persons* enrolled on the Manchester campus of UNH or children enrolled in the SHBP. Certain other preventive care services are provided in addition to the mandated coverage under the PPACA. Refer to other sections of the Schedule of Benefits for copayment and coinsurance requirements.	$0 Copayment/$0 Coinsurance. For SHBP Covered Durham campus students and spouses, benefits are covered only at UNH Health Services, except as specifically provided.	Not Covered
Lab, X-Ray and Clinical Tests	85%.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Routine Newborn Care – In Hospital (Including *Provider/ Practitioner* visits and circumcision)	85% ($250 copayment per admission is waived).	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Allergy Injections (If not billed with an office visit)	85%.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Anesthesia (Inpatient/Outpatient)	85%.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Maternity Care (Includes prenatal care, delivery, and postpartum care) for *Provider*/*Practitioner* Services	$30 copayment per visit, then 100% coverage thereafter.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).

MEDICAL BENEFITS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Second and Third Surgical Opinion	85%.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Surgery (Inpatient and outpatient)	$100 copayment per surgery, then 85% coverage thereafter.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Provider/Practitioner Home and Office Visits Charges Including diagnostic Lab, X-ray, and Clinic Tests that are billed by the *Provider/Practitioner*.	$30 copayment per visit, then 100% coverage thereafter.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Provider/Practitioner Hospital Visits	85%.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Urgent Care Services • **Students Covered by UNH Health and Counseling Fee**	$35 copayment per visit, then 85% coverage thereafter (not applicable when services are covered by the UNH Health Services and Counseling Fee at Wentworth Douglass Hospital).	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
• **All Other Students and Dependents**	$35 copayment per visit, then 85% coverage thereafter.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Preadmission/Precertification for Inpatient Hospitalizations Required: All inpatient hospitalizations should be certified or coinsurance may be reduced for *In-Network Provider* services and *Out-of-Network Provider* services. Contact Complex Case Management at (800) 633-7867 to certify a *Hospital* stay – including *Emergency Medical Services* – within 48 hours. Refer to Section VIII entitled Preadmission/Precertification for a more complete explanation.		
Birthing Center	$250 copayment per admission, then 85% coverage thereafter.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Hospital Room and Board	$250 copayment per admission, then 85% coverage thereafter of the *Hospital's* semi-private room rate and special care unit.	80% of *Reasonable and Customary Charges* of the *Hospital's* semi-private room rate and special care unit (after annual *Plan Year* deductible).

Hospital Miscellaneous Expenses	85%.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Intensive Care Unit	$250 copayment per admission, then 85% coverage thereafter.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Maternity Services	$250 copayment per admission, then 85% coverage thereafter.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Newborn Care – In Hospital (Including *Provider*/*Practitioner* visits and circumcision)	100% ($250 copayment is waived).	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Organ Transplants (Limitations Apply. Refer to Section VII: Covered Medical Services, Subsection EE: Organ Transplant Benefits)	$250 copayment per admission, then 85% coverage thereafter.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Surgical Facilities and Supplies	85%.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Clinic Services (At a *Hospital*)	$30 copayment per visit, then 100% coverage thereafter.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Emergency Room Expenses – Medically Necessary (Facility, Lab, X-ray, and *Provider*/*Practitioner* services). Copayment is waived if admitted.	$75 copayment per visit, then 85% coverage thereafter.	$75 Copayment (not subject to annual *Plan Year* deductible) then 85% of *Reasonable and Customary Charges*.
Outpatient Hospital Departments	85%.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc.	$100 copayment per surgery, then 85% coverage thereafter.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Preadmission Testing	85%.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).

MENTAL HEALTH/ SUBSTANCE ADDICTION /ABUSE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Biologically-Based Mental Illness conditions are not subject to the limits shown below for Inpatient and Outpatient *Mental or Nervous Disorder* and *Substance Addiction*/*Abuse* Treatment.[1, 4]		
Day Treatment/Inpatient Mental or Nervous Disorder Treatment and Alcoholism and Substance Addiction/Abuse Treatment (Includes *Provider*/ *Practitioner* visits).[2]	$250 copayment per admission, then 85% coverage thereafter up to a maximum of 30 days per person or 60 partial days per person, per *Plan Year* for all services combined.[3]	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible) and up to a maximum of 30 days per person or 60 partial days per person, per *Plan Year* for all services combined.[3]
Outpatient Mental or Nervous Disorder Treatment/ Alcoholism and Substance Addiction/Abuse Treatment	$15 copayment per visit, then 100% coverage thereafter up to a maximum of 30 visits per person, per *Plan Year* for all services combined.[3, 4]	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible) up to a maximum of 30 visits per person, per *Plan Year* for all services combined.[3]

[1] *Biologically-Based Mental Illnesses* will be paid the same as any other *Illness* according to the medical benefit level and are not subject to the thirty (3) days per person, per *Plan Year* maximum. These charges are subject to review for *Medical Necessity*.

[2] Every day of inpatient treatment will reduce the number of remaining partial *Day Treatment* days by two (2) days. Conversely, every two (2) days of *Day Treatment* will reduce the number of remaining inpatient treatment days by one (1) day.

[3] These are combined maximums for *In-Network Providers* and *Out-of-Network Providers*.

[4] Coverage for outpatient treatment for both *Biologically-Based Mental Illnesses* and outpatient *Mental or Nervous Disorders*/*Alcoholism* or *Substance Addiction*/*Abuse* is subject to *Medical Necessity* review after 15 visits.

OTHER SERVICES AND SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Acupuncture	$30 copayment per visit, then 85% coverage thereafter up to a maximum of $1,000* per person, per *Plan Year*.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible) up to a maximum of $1,000* per person, per *Plan Year*.
Ambulance Services	$100 copayment per trip, then 85% coverage thereafter.	$100 copayment per trip, then 85% of *Reasonable and Customary Charges* (deductible waived).
Cardiac Rehabilitation	$30 copayment per visit, then 85% coverage thereafter up to a maximum 12-week* program per person, per cardiac event.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible) up to a maximum 12-week* program per person, per cardiac event.
Chemotherapy and Radiation Therapy	85%.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Chiropractic Services and Physical Therapy All outpatient rehabilitation services are subject to a combined maximum of 20 visits per *Plan Year*.*	$30 copayment per visit, then 85% coverage thereafter.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Dental Care (Limited to treatment of *Injury* to sound natural teeth)	85% up to a maximum of $2,500 per person, per *Plan Year*.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible) up to a maximum of $2,500 per person, per *Plan Year*.
Diabetes Self-Management Education and Training	$30 copayment per visit, then 85% thereafter.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Diagnostic X-ray, Lab and Other Clinical Tests	85%.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).

OTHER SERVICES AND SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Diagnostic Imaging (e.g., PET, CAT, DEXA, MRI scans, and ultrasound)	$100 copayment per procedure, then 85% coverage thereafter.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible)
Hemodialysis	85%.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Home Health Care	85% up to a maximum of one* visit (4-hour limit) within a 24-hour period, and further limited to 120 visits* per person, per lifetime.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible) up to a maximum of one* visit (4-hour limit) within a 24-hour period, and further limited to 120 visits* per person, per lifetime
Home Hospice Care	85%.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Durable Medical Equipment	85%.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Elective Termination of Pregnancy	85%.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Metabolic Formula and Special Modified Low Protein Food Products The $1,800 maximum does not apply to formula or foods that require a prescription from a *Provider*/*Practitioner*.	85%; special modified low protein food products are limited to $1,800* per person, per *Plan Year*.	80 of *Reasonable and Customary Charges* (after annual *Plan Year* deductible); special modified low protein food products are limited to $1,800* per person, per *Plan Year*.
Occupational Therapy	$30 copayment per visit, then 85% coverage thereafter.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).

OTHER SERVICES AND SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Private Duty Nursing	85%.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Skilled Nursing/Extended Care/Rehabilitation Facility	85%.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Speech Therapy	$30 copayment per visit, then 85% coverage thereafter.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Temporomandibular Joint Disorders (TMJ) – Diagnosis Only	$30 copayment per visit, then 85% coverage thereafter.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Wigs (when hair loss is due to cancer, a medical condition, or *Injury*)	85%.	80% of *Reasonable and Customary Charges* (after annual *Plan Year* deductible).
Repatriation Return of *Covered Person's* mortal remains to home country or permanent home residence.	100% percent coverage of actual charges up to a maximum benefit of $10,000. Transportation arrangements must be coordinated and approved by FrontierMedex.	
Emergency Medical Evacuation Return of Covered Person to home country or permanent residence.	100% coverage of *Reasonable and Customary Charges* for *Medically Necessary* transportation to return student to his or her home country or permanent residence. Transportation arrangements must be coordinated and approved by FrontierMedex.	

*These are combined maximums for *In-Network Providers* and *Out-of-Network Providers*.

Preventive Care Benefits are provided by the SHBP in full compliance with the Patient Protection and Affordable Care Act (PPACA) if the service or supply is available at UNH Health Services. This limitation does not apply for services received at *In-Network Providers* if:

- the PPACA Preventive Care mandated service or supply is not provided by UNH Health Services;
- the *Student* receives the service or supply outside of the *Durham Area; or*
- the SHBP-*Covered Person* is not eligible to obtain the service or supply from the UNH Health Service.

PPACA Preventive Care Benefits are provided at 100% percent reimbursement as specified in the Schedule of Benefits for services received at UNH Health Services and services received at *In-Network Providers* as specified in this section

The SHBP also provides certain preventive care benefits and services that exceed requirements of the PPACA; these benefits and services are provided in the section entitled Covered Medical Services, and are provided pursuant to the Schedule of Benefits.

PPACA Preventive Care Benefits are subject to change, pursuant to determinations by the U.S. Department of Health and Human Services and the **U.S. Preventive Services Task Force**. **Refer to the SHBP website for updates.**

A. Covered Preventive Services for Adults (age 19 or over)

- Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked.
- Alcohol misuse screening and counseling.
- Aspirin use for men and women of certain ages.
- Blood pressure screening for all adults.
- Cholesterol screening for adults of certain ages or at higher risk.
- Colorectal cancer screening for adults over age 50.
- Depression screening for adults.
- Type 2 diabetes screening for adults with high blood pressure.
- Diet counseling for adults at higher risk for chronic disease.
- HIV screening for all adults at higher risk.
- Immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
    - hepatitis a
    - hepatitis b
    - herpes zoster
    - human papillomavirus
    - influenza (flu shot)
    - measles, mumps, rubella
    - meningococcal
    - pneumococcal
    - tetanus, diphtheria, pertussis

- varicella

- Obesity screening and counseling for all adults
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Tobacco Use screening for all adults and cessation interventions for tobacco users
- Syphilis screening for all adults at higher risk

B. **Covered Preventive Services for Women, Including Pregnant Women**

- Anemia screening on a routine basis for pregnant women.
- Bacteriuria urinary tract or other infection screening for pregnant women.
- BRCA counseling about genetic testing for women at higher risk.
- Breast cancer mammography screenings every 1 to 2 years for women over 40 years.
- Breast cancer chemoprevention counseling for women at higher risk.
- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women.
- Cervical cancer screening for sexually active women.
- Chlamydia infection screening for younger women and other women at higher risk.
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
- Domestic and interpersonal violence screening and counseling for all women.
- Folic acid supplements for women who may become pregnant.
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
- Gonorrhea screening for all women at higher risk.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women.
- Human papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are age 30 or older.
- Osteoporosis screening for women over age 60 depending on risk factors.
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
- Tobacco screening and interventions for all women, and expanded counseling for pregnant tobacco users.
- Sexually transmitted infections (STI) counseling for sexually active women.
- Syphilis screening for all pregnant women or other women at increased risk.
- Well-woman visits to obtain recommended preventive services for women under age 65.

C. Covered Preventive Services for Children

- Alcohol and Drug Claims Administrator assessments for adolescents.
- Autism screening for children at 18 and 24 months.
- Behavioral assessments for children of all ages (up to age 18).

- Blood Pressure screening for children (up to age 18).
  Cervical Dysplasia screening for sexually active females.
- *Congenital* Hypothyroidism screening for newborns.
- Depression screening for adolescents.
- Developmental screening for children under age 3, and surveillance throughout childhood.
- Dyslipidemia screening for children at higher risk of lipid disorders (up to age 18). Fluoride chemoprevention supplements for children without fluoride in their water source.
- Gonorrhea preventive medication for the eyes of all newborns.
- Hearing screening for all newborns.
- Height, weight and body mass index measurements for children. (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)
- Hematocrit or hemoglobin screening for children.
- Hemoglobinopathies or sickle cell screening for newborns.
- HIV screening for adolescents at higher risk.
- Immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary) including:

  - diphtheria, tetanus, pertussis
  - haemophilus influenzae type b
  - hepatitis a
  - hepatitis b
  - human papillomavirus
  - inactivated poliovirus
  - influenza (flu shot)
  - measles, mumps, rubella
  - meningococcal
  - pneumococcal
  - rotavirus
  - varicella

- Iron supplements for children ages 6 to 12 months at risk for anemia.
- Lead screening for children at risk of exposure.
- Medical history for all children throughout development. (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)
- Obesity screening and counseling.
- Oral health risk assessment for young children (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years).
- Phenylketonuria (PKU) screening for this genetic disorder in newborns.
- Sexually transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk.
- Tuberculin testing for children at higher risk of tuberculosis (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, and 15 to 17 years).
- Vision screening for all children.

A. Hospital Charges

Room and board and other professional services on an inpatient or outpatient basis are covered, including:

(1) *Preadmission Tests* on an outpatient basis for a scheduled *Hospital* admission or surgery provided the tests are done within seven (7) days of the planned admission, and the surgery and the tests are accepted by the *Hospital* in place of the same post-admission tests;

(2) *Hospital* charges for room and board in a semiprivate room, *Intensive Care Unit*, cardiac care unit, or burn care unit, but excluding charges for a private room (unless *Medically Necessary*) which are in excess of the *Hospital's* semiprivate room rate (charges made by a *Hospital* having only private rooms will be considered at 80% of the private room rate [i.e., 20% of the charge for private room will be excluded before benefits are determined]);

(3) *Routine Nursery Care* (including circumcision and *Provider*/*Practitioner* visits) while confined, even though no sickness or *Injury* exists;

(4) *Hospital* charges for necessary medical supplies and services, including X-rays, laboratory, and anesthetics and the administration thereof;

(5) *Hospital* charges for drugs and medicines obtained through written prescription by a *Provider*/*Practitioner*;

(6) outpatient surgical services performed at a *Provider's/Practitioner's* office, *Ambulatory Surgical Center*, the outpatient department of a *Hospital*, *Birthing Center* or *Freestanding Health Clinic*;

(7) *Birthing Center* or *Freestanding Health Clinic* (Payment will be limited to the amount that would have been paid if that person were in a *Hospital*.*)*;

(8) radiation, chemotherapy, or hemodialysis (renal therapy) at a *Medicare*-approved dialysis center;

(9) administration of infusions and transfusions (this includes the cost of unreplaced blood and blood plasma or autologous blood and blood plasma: expenses for storage of autologous blood or blood plasma will not be covered);

(10) inpatient respiratory, physical, occupational, inhalation, speech, and cardiac rehabilitation therapy;

(11) emergency room; and

(12) outpatient department.

Day treatment/inpatient confinement in a licensed general *Hospital*, in a mental *Hospital* under the direction and supervision of the Department of Mental Health, or in a private mental *Hospital* licensed by the Department of Mental Health, or confinement in a public or private *Alcoholism*/*Substance Addiction*/*Abuse* facility, for the treatment of a *Mental or Nervous Disorder* or *Alcoholism*/*Substance Addiction*/*Abuse*, is covered as described in the Schedule of Benefits up to a combined maximum (with inpatient *Alcoholism*/*Substance Addiction*/*Abuse* treatment) of thirty (30) days per person or sixty (60) partial days per person, per *Plan Year*.
Note: *Biologically-Based Mental Illness*es will be paid as any other *Illness* and shall not be subject to the thirty (30) day maximum per person or sixty (60) partial days per person, per *Plan Year*.

Day treatment/inpatient confinement in a public or private *Alcoholism*/*Substance Addiction*/*Abuse* facility for the treatment of *Alcoholism* and *Substance Addiction*/*Abuse* is covered as described in the Schedule of Benefits up to a combined maximum (with inpatient *Mental or Nervous Disorder* treatment) of thirty (30) days per person or sixty (60) partial days per person, per *Plan Year*.

Every day of inpatient treatment will reduce the number of remaining *Day Treatment* days by two (2) days. Conversely, every two (2) days of *Day Treatment* will reduce the number of remaining inpatient treatment days by one (1) day.

B. Skilled Nursing/Extended Care Facilities

Inpatient confinement in a *Skilled Nursing*/extended care facility and/or in a rehabilitation facility/*Hospital* is covered if:

(1) charges are incurred within fourteen (14) days following a *Hospital* confinement which lasted three (3) days; and

(2) the attending *Provider*/*Practitioner* certifies that 24 -nursing care is *Medically Necessary* for recuperation from the *Illness* or *Injury* which required the *Hospital* confinement.

C. Ambulance Services

Ambulance services are covered provided the conveyance is:

(1) to the nearest *Hospital* or medical facility which is equipped to provide the service required;

(2) from a *Hospital* when *Medically Necessary*, or

(3) an air ambulance or rail transportation when it is:

(a) required because the life of the patient would be endangered through the use of any other form of transportation; and

(b) used to transport the patient to the nearest medical facility equipped to provide care.

D. Diagnostic X-ray and Laboratory Services

Charges incurred for X-rays, microscopic tests, laboratory tests, allergy testing, allergy injections, electrocardiograms, electroencephalograms, pneumoencephalograms, and basal metabolism tests, or similar well-established diagnostic tests generally approved and performed by *Providers*/*Practitioners* throughout the United States.

E. Diagnostic Imaging and Scans

Charges incurred for diagnostic imaging and general imaging, including but not limited to, ultrasounds, MRI/MRA, CT/CAT and PET scans, and nuclear medicine.

F. Emergency Facilities

Charges incurred for *Medically Necessary* care for *Emergency Medical S*ervices at an emergency treatment center, walk-in medical clinic, or ambulatory clinic (including clinics located at a *Hospital*).

G. Provider/Practitioner Services

Charges made by legally-licensed *Providers*/*Practitioners* for medical care and/or treatment including office visits, home visits, diagnostic eye exam, *Hospital* inpatient care, *Hospital* outpatient visits/exams, and clinic care.

H. Second and Third Surgical Opinions

Charges incurred for a second surgical opinion, and, in some instances, a third opinion, provided:

(1) fees of a legally-qualified *Provider*/*Practitioner* for a second surgical consultation when non-*Emergency* or elective surgery is recommended by the *Covered Person's* attending *Provider*/*Practitioner* (the *Provider*/*Practitioner* rendering the second opinion regarding the *Medical Necessity* of such surgery must be qualified to render such a service, either through experience, specialization training, education, or similar criteria, and must not be affiliated in any way with the *Provider*/*Practitioner* who will be performing the actual surgery); and

(2) fees of a legally-qualified *Provider*/*Practitioner* for a third consultation, if the second opinion obtained does not concur with the first *Provider's/Practitioner's* recommendation (this third *Provider*/*Practitioner* must be qualified to render such a service and must not be affiliated in any way with the consulting *Provider*/*Practitioner* or with the *Provider*/*Practitioner* who will be performing the actual surgery).

I. Anesthesia Services

Charges by a *Provider*/*Practitioner* incurred for a surgical operation and for the administration of anesthesia.

J. Multiple Surgical Procedures

If two or more surgical procedures are performed at one time through the same incision in the same operative field, the maximum allowable amount for the surgery will be either the fee schedule amount for the primary procedure and 50% of the fee schedule amount for the secondary or lesser procedure(s), or if not in the network, the *Reasonable and Customary Charge* for the major procedure and 50% of the *Reasonable and Customary Charge* for the secondary or lesser procedure(s). No additional benefit will be paid under the SHBP for incidental surgery done at the same time and under the same anesthetic as another surgery.

K. Assistant Surgeons

Surgical assistant charges when the nature of the procedure is such that the services of an assistant, who is a *Provider*/*Practitioner*, are *Medically Necessary*.

L. Dental Injury Related Services

The following dental procedures, including related *Hospital* expenses (when deemed to be *Medically Necessary*), will be covered the same as any other *Illness* provided:

(1) treatment of an *Injury* to a sound natural tooth, other than from eating or chewing, including replacement of teeth and any related X-rays; and

(2) dental services for children under the age of six who have a dental condition of significant complexity, or for *Covered Person*s who have exceptional medical circumstances or developmental disabilities for which *Medically Necessary Hospital* or surgical day care facility services, including administration of general anesthesia, are required, except as defined under Medical Benefit Exclusions.

M. Cosmetic Surgery

Charges for cosmetic purposes or for cosmetic surgery if required due solely as the result of:

(1) an *Accidental* bodily *Injury*, providing that coverage is in effect at the time that the *Injury* and treatment occur;

(2) a birth defect of a covered dependent child, provided coverage is in effect at the time that the child is born and at the time that treatment occurs; or

(3) surgical removal of diseased tissue as a result of an *Illness*. *Covered Persons* electing breast reconstruction, following a mastectomy, are also covered for reconstruction of the other breast to produce symmetrical appearance, and coverage for prostheses and physical complications of all stages of a mastectomy (the reconstruction procedure will be performed in a manner determined between the *Providers*/*Practitioners* and the patient).

N. Miscellaneous Surgical Procedures

Charges for surgical procedures including circumcision and termination of pregnancy. Amniocentesis is included if deemed *Medically Necessary*. No benefits will be payable if amniocentesis is performed only to determine the sex of an infant before birth and for women under age thirty-five (35) unless certified as *Medically Necessary* by a *Provider*/*Practitioner*.

O. Mental or Nervous Disorder, Chemical Dependency and Substance Addiction/Abuse

Charges for the treatment of *Mental or Nervous Disorders* on an outpatient basis, up to a combined maximum (with outpatient *Alcoholism*/*Substance Addiction*/*Abuse* treatment) of thirty (30) visits per person, per *Plan Year*.

Charges for the treatment of *Alcoholism* and *Substance Addiction*/*Abuse* on an outpatient basis, up to a combined maximum (with outpatient *Mental or Nervous Disorder* treatment) of thirty (30) visits per person, per *Plan Year*. Services must be furnished by:

(1) a comprehensive health service organization;

(2) a licensed or accredited *Hospital*;

(3) a community mental health center, or other mental health clinic or day care center which furnishes mental health services, subject to the approval of the Department of Mental Health;

(4) a licensed detoxification facility;

(5) a licensed social worker; or

(6) a psychiatrist.

Provider(s)/*Practitioner(s)* visits for medication management will be considered separately and will not accumulate toward the *Mental or Nervous Disorder* benefit annual or period of coverage maximums.

Note: *Biologically-Based Mental Illnesses* are covered the same as any other *Illness* and are not subject the outpatient *Plan Year* maximum of thirty (30) visits.

P. Chiropractic Care

Charges made by a licensed chiropractor (allowed visits are combined with Physical Therapy services).

Q. Podiatry Services

Charges incurred for *Medically Necessary* treatment of the feet, including treatment of metabolic or peripheral vascular disease.

R. Nursing Services

Services by a private duty nurse are eligible expenses (24-hour private duty nursing care is not a *Covered Expense*) when furnished by a Registered Nurse (R.N.), or Licensed Practical Nurse (L.P.N.), for necessary nursing care as evidenced by a written statement from the attending *Provider*/*Practitioner*, providing that the nurse is not an immediate member of the *Covered Person's* family and does not reside in the *Covered Person's* home. Charges billed by a Visiting Nurse Association for such services are included.

S. Diabetic Care

Charges incurred for ambulatory diabetic self-management training and education, including:

(1) medical nutrition therapy, used to diagnose or treat insulin dependent diabetes, non-insulin dependent diabetes, or gestational diabetes;

(2) blood sugar kits, insulin and insulin infusion pumps, diabetic supplies for testing blood and urine specimens at home, syringes, monitors, or test strips and lancets; and

(3) approved self-management education training as well as professional instructions, excluding printed material.

T. Home Health Care Services

Charges made by a *Home Health Care Agency* for care in accordance with a *Home Health* Plan. Such expenses include charges for:

(1) part-time or intermittent nursing care rendered by a Registered Nurse (R.N.);

(2) a Licensed Practical Nurse (L.P.N.), a vocational nurse, or a public health nurse who is under the direct supervision of a Registered Nurse;

(3) *Home Health* aides; and

(4) medical supplies, drugs, and medications prescribed by a *Provider*/*Practitioner* and laboratory services by, or on behalf of, a *Hospital* to the extent

that such items would have been covered by the SHBP had the *Covered Person* remained in the *Hospital*.

Home Health care means a visit by a member of a *Home Health* care team. Each such visit that lasts for a period of 4 hours or less is treated as one (1) visit. No benefits will be provided for services and supplies not included in the *Home Health Plan*, services of any social worker, transportation services, *Custodial Care* and housekeeping, or for services of a person who ordinarily resides in the home of the *Covered Person*, or is a close relative of the *Covered Person*.

U. Outpatient Rehabilitation Services

Charges incurred for outpatient rehabilitative therapy services include the following expenses.

(1) Charges incurred for the treatment or services rendered by a physical therapist under direct supervision of a *Provider*/*Practitioner* in a home setting, at a facility or institution whose primary purpose is to provide medical care for an *Illness* or *Injury*, at a *Freestanding Health Clinic*, or at a duly-licensed outpatient therapy facility (visit limits are combined with Chiropractic Care services).

(2) Charges incurred for inhalation therapy under the direct supervision of a *Provider*/*Practitioner* in a home setting, at a facility or institution whose primary purpose is to provide medical care for an *Illness* or *Injury*, or at a freestanding duly-licensed outpatient therapy facility.

(3) Charges incurred for the treatment and services rendered by a registered occupational therapist to restore physical function and provided under the direct supervision of a physician in a home setting, at a facility or institution whose primary purpose is to provide medical care for an *Illness* or *Injury*, or at a freestanding duly-licensed outpatient therapy facility.

(4) Charges incurred for the services of a legally-qualified speech therapist under the direct supervision of a physician for restorative or rehabilitative speech therapy due to speech loss or impairment, other than a functional *Mental or Nervous Disorder*, or due to surgery performed on account of an *Illness* or *Injury*. If speech loss is due to a *Congenital* anomaly, surgery to correct the anomaly must have been performed prior to therapy.

(5) Charges incurred for cardiac rehabilitation program (limited to Phase I and Phase II only), provided such treatment is recommended by the attending *Provider*/*Practitioner* up to a maximum of twelve (12) weeks per person, per cardiac event. Phase I consists of acute inpatient hospitalization, whether for heart attack or heart surgery, which is highly supervised and with a tailored exercise program with continuous monitoring during exercise. Phase II consists of outpatient supervised treatment for *Covered Persons* who have left the *Hospital* but still need a certain degree of supervised physical therapy and

monitoring during exercise. Phase II services are usually tailored to meet the *Covered Person's* individual needs. Benefits are not payable for Phase III, which consists of outpatient services without supervision. The Phase III program is developed for patients who are well enough to continue exercising on their own while monitoring their own progress.

V. Pregnancy Care

Expenses relating to pregnancy and birthing are covered according to the following schedule.

(1) Prenatal care of the mother and/or fetus is treated as any other *Illness* or *Injury* covered under the SHBP.

(2) Inpatient care for the mother and/or newborn child will be provided for a minimum of 48 hours following a vaginal delivery, or a minimum of 96 hours following a cesarean section. However, the mother's or newborn's attending health care *Provider*/*Practitioner*, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

(3) No authorization from the SHBP need be sought by the attending *Provider*/*Practitioner* for prescribing a length of inpatient stay for the mother or newborn not in excess of 48 hours (or 96 hours, as applicable). In any case, the 48- or 96-hour limit may be exceeded with authorization of the Claim Administrator in cases of *Medical Necessity*.

W. Mastectomy Care

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner to be determined in consultation with the attending *Provider*/*Practitioner* and the patient, for:

(1) all stages of reconstruction of the breast on which the mastectomy was or is to be performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(3) prostheses; and

(4) treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductible, coinsurance, and/or copayments applicable to other medical and surgical benefits provided under the SHBP.

X. Miscellaneous Medical Services and Supplies

1) Charges for expendable supplies including, but not limited to, prescription drugs, medicines, oral contraceptives, contraceptive devices and Depo Provera® injections, insulin, surgical bandages, syringes, dressings, surgical supports, head halters, colostomy bags, catheters, crutches, splints, casts, trusses, traction apparatus, and cervical collars.

(2) Charges for oxygen and other gasses and their administration.

(3) Charges for the rental or the purchase (whichever is less) of prosthetic appliances to aid impaired functions including, but not limited to, wheelchairs, standard *Hospital*-type beds, mechanical respirators, iron lungs, bed rails, equipment for the administration of oxygen, *Hospital*-type equipment for hemodialysis, kidney or renal dialysis (including training of a person to operate and maintain equipment), and other *Medically Necessary* durable medical or surgical equipment. Expenses related to necessary repairs and maintenance are also covered.

(4) Charges for wigs and artificial hairpieces, only after chemotherapy or radiation therapy, or when it is disease- or *Injury*-related and not due to the normal aging process or premature baldness.

(5) Charges for appliances, prostheses, and orthopedic braces such as artificial arms and legs including accessories; orthotics, orthopedic or corrective shoes, and other supportive appliances for the feet (when *Medically Necessary* due to an *Injury* or *Illness*); arm, back, and neck braces; surgical supports; head halters; larynx appliances; eye prostheses; and breast prostheses (when *Medically Necessary* for breast removal); and surgical brassieres (limited to two (2) per person, per *Plan Year*) when purchased following a mastectomy. Replacement, repair, or adjustment is covered only when necessary due to physiological changes, or the replacement is less expensive than the repair of existing equipment.

(6) Charges for compression therapy garments (e.g., Jobst® garments) when *Medically Necessary* due to an *Injury* or *Illness*.

(7) Charges for chemotherapy (antineoplastic) when drugs are taken by infusion, perfusion, intracavity, or parenteral means.

(8) Charges for *Medically Necessary* routine patient care incurred as a result of a treatment being provided in accordance with a clinical trial, to the extent that such costs would be covered by non-investigative treatments, if the treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer, or the treatment is being provided for any other life-threatening condition. Coverage for Phase I or Phase II clinical trials shall be decided on a case-by-case basis. Coverage is provided if:

(a) treatment is being provided by an approved clinical trial;

(b) standard treatment has been or would be ineffective, does not exist, or there is no superior non-*Investigational* treatment alternatives;

(c) the facility and personnel providing the treatment are capable of doing so by virtue of their experience and education; and

(d) available clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-*Investigational* alternative.

(9) Charges for services related only to diagnosis of temporomandibular joint (TMJ) disorders (treatment of TMJ disorders is not covered).

(10) Charges for growth hormones when prescribed by a board-certified pediatric endocrinologist and a written treatment plan is submitted for approval of the Claims Administrator. The *Covered Person* must be seen by the attending *Provider*/*Practitioner* every six (6) months and a written response to the treatment must be verified by the *Provider*/*Practitioner*. The medication will be covered for a thirty (30) day supply at a time;

(11) Charges for allergy testing and treatment, including preparation of serum and injections.

(12) Charges for titer when *Medically Necessary* and not for routine testing.

(13) Charges, to the extent defined herein, for services provided to children in addition to or in lieu of the services which may be available, provided, and/or used under a federal or state mandated program such as the Individual with Disabilities Educational Act, Public Law 105-17.

(14) Charges for applicable state surcharges on covered benefits paid under the SHBP for which the *Covered Person* is legally liable, to the extent required by law.

(15) Charges for other *Medically Necessary* services and supplies as prescribed by the attending *Provider*/*Practitioner* and determined to be *Medically Necessary* by the Claims Administrator.

Y. Hospice Care Benefits

Hospice care benefits are provided to a terminally-ill *Covered Person* with a life expectancy of less than six (6) months; or to members of his or her immediate family. Benefits are limited to:

(1) room and board for a confinement in an *Inpatient Hospice Facility*;

(2) ancillary charges furnished by the *Inpatient Hospice Facility* while the patient is confined therein, including rental of durable medical equipment which is used solely for treating an *Injury* or *Illness*;

(3) medical supplies, drugs, and medicines prescribed by the attending *Provider*/*Practitioner*, but only to the extent that such items are necessary for pain control and management of the terminal condition;

(4) *Provider*/*Practitioner* services and/or nursing care by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or a Licensed Vocational Nurse (L.V.N.);

(5) *Home Health* aide services;

(6) charges for home care furnished by a *Hospital* or *Home Health Care Agency*, under the direction of a *Hospice*, including *Custodial Care* if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse, or a *Home Health* aide;

(7) medical social services by licensed or trained social workers, psychologists, or counselors;

(8) nutrition services provided by a licensed dietitian;

(9) respite care; and

(10) bereavement counseling.

Bereavement counseling is a support service provided by the *Inpatient Hospice Facility* team to *Covered Persons* in the deceased's immediate family after the death of such terminally-ill person. Such visits are to assist the *Covered Persons* in adjusting to the death. Benefits will be payable provided:

(a) on the date immediately before his or her death, the terminally-ill person was in a *Hospice Plan of Care* program and was a *Covered Person* under the SHBP; and

(b) charges for such services are incurred by the *Covered Person(s)* within six (6) months of the terminally-ill person's death.

The term immediate family means: parents, spouse (or same-sex domestic partner) and children of the terminally-ill *Covered Person*.

Z. Organ Transplant Benefits

Expenses for an organ and/or tissue transplant will be subject to the following requirements.

(1) Covered Organ Transplants

human heart	kidney
bone marrow	cornea
liver	pancreas
lung	intestinal
multivisceral	

(2) Preauthorization Requirement for Organ Transplants

Inpatient *Hospital Expenses Incurred* in connection with any organ or tissue transplant will be subject to Preadmission/Precertification Requirement for Hospitalization as described in Section VIII of this Plan Document entitled Preadmission/Precertification. All potential transplant cases will be assessed for their appropriateness for Large Case Management.

(3) Transplant Benefit Period

Covered transplant expenses will accumulate during a Transplant Benefit Period and will be charged toward the Transplant Benefit Period maximums, if any, shown in the Schedule of Benefits. The term Transplant Benefit Period means the period which begins on the date of the initial evaluation and ends on the date which is twelve (12) consecutive months following the date of the transplant. If the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant.

(4) Covered Transplant Expenses

Covered Expenses, with respect to transplants, refers to the fee schedule amount of *In-Network Providers*, or if not in the network, the *Reasonable and Customary Charges* for services and supplies which are covered under the SHBP (or which are specifically identified as covered only under this provision) and which are *Medically Necessary* and appropriate to the transplant. Such *Covered Expenses* include:

(a) charges incurred in the evaluation, screening, and candidacy determination process;

(b) charges incurred for organ transplantation; and

(c) charges for organ procurement, including donor expenses which are not covered under the donor's plan of benefits, subject to the following:

- Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving, and transporting the organ.

- Coverage for organ procurement from a living donor will be provided for the costs involved in screening the potential donor, as well as for medical expenses employed with removal of the donated organ and the related medical services provided to the donor in the interim and for follow-up care.

- If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the *Covered Person's* bone marrow (autologous) or donated marrow (allogenic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the marrow, up to the time of reinfusion. The harvesting of the marrow need not be performed within the Transplant Benefit Period.

- Coverage will be provided for follow-up care, including immunosuppressant therapy.

- Coverage will be provided for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual or in the event that the recipient or the donor is a minor, two other individuals. In addition, all reasonable and necessary lodging and meal *Expenses Incurred* during the Transplant Benefit Period will be covered.

(5) Re-Transplantation

Up to two re-transplants, for a total of three transplants, will be covered per person, per lifetime. Each transplant and re-transplant will have a new Transplant Benefit Period and a new maximum benefit.

(6) Donor Expenses

If the recipient is not covered under the SHBP, but the donor is, neither the donor nor the recipient is eligible for coverage; however,

(a) if both the donor and recipient are covered under the SHBP, eligible charges incurred by both patients will be covered; or

(b) if the recipient is covered under the SHBP, but the donor is not, the SHBP will provide coverage for eligible charges to both the recipient and donor as long as similar benefits are not available to the donor from other coverage sources.

AA. **Repatriation Benefits**

In the event of the death of an *Covered Person*, the SHBP will pay the actual charges incurred for preparing and transporting that person's remains to his or her home country or permanent residence. Benefits are provided in accordance with legal requirements in effect at the time the bodily remains are to be returned. The death must occur while the person is covered by the SHBP. Return of Mortal Remains must be approved in advance by FrontierMEDEX.

BB. **Emergency Medical Evacuation Benefits**.

The SHBP will pay benefits up to the Reasonable and Customary Charge incurred if an Injury or Illness results in the Emergency Evacuation of the Covered Person. Covered Expenses are expenses for transportation, medical services and medical supplies necessarily incurred in connection with an *Emergency Evacuation* of the *Covered Person*. All transportation arrangements made for evacuating the Insured Person must be: a) by the most direct and economical conveyance; and b) approved in advance by FrontierMEDEX.

Transportation means any land, water or air conveyance required to transport the Insured Person during an *Emergency Evacuation*. Expenses for special transportation must be: a) recommended by the attending physician; or b) required by the standard regulations of the conveyance transporting the *Covered Person*. Special transportation includes, but is not limited to; Air Ambulance, land Ambulance, and private motor vehicle. Expenses for medical supplies and services must be recommended by the attending Physician and approved by FrontierMEDEX.

Services under this Benefit include:

- Medical Consultation, Evaluation and Referrals.
- Foreign Hospital Admission Guarantee.
- Emergency Medical Evacuation.
- Critical Care Monitoring.
- Medically Supervised Repatriation.
- Prescription Assistance.
- Transportation costs for one (1) family member to Join Patient.
- Return of Mortal Remains.
- Emergency Counseling Services.
- Lost Luggage or Document Assistance.
- Interpreter and Legal Referrals.

A. Hospital Confinement and Emergency Admissions

For any period of *Hospital* confinement commencing on or after the *Covered Person's Effective Date* of coverage under the SHBP, all benefits available to a *Covered Person* for inpatient care may be subject to a reduction in benefits, unless such period of confinement has been authorized by the Claims Administrator. The reduction in charges not covered cannot be used to satisfy copayments, deductibles, and out-of-pocket maximums described elsewhere herein.

The Preadmission/Precertification service will also authorize the number of days of hospitalization required based upon the information provided. In the event the number of days of hospitalization exceeds the number of precertified days, the additional days will not be an eligible expense under the provisions of the SHBP, unless certified as *Medically Necessary* care by the Preadmission/Precertification service.

In the event of an *Emergency* or if the *Covered Person* is confined to the *Hospital's* observation area for more than 24 hours, it is necessary that the *Covered Person* contact the Preadmission/Precertification service within 48 hours after an admission or on the first business day following admission. If authorization is not obtained, the reduction in benefits described above applies.

The Preadmission/Precertification requirement applies to maternity admissions as well; however, the penalty for failure to precertify a *Hospital* stay will be waived if an admission is no longer than 48 hours for a vaginal delivery, or no longer than 96 hours for a cesarean delivery.

B. Case Management Provision for Alternate Treatment

In cases where a *Covered Person's* condition is, or is expected to be, of a serious nature, the Plan Administrator may arrange for review and/or case management services from a professional qualified agency. This service involves the cost-effective voluntary management of a potentially high-cost claim for a high-risk or long-term medical condition. The intention of the service is to plan necessary, quality care in the most cost-effective manner with the approval of the *Covered Person*, family, and attending *Provider(s)/Practitioner(s)*.

In the event a *Covered Person* is identified as a candidate for case management, then upon approval of the attending *Provider(s)/Practitioner(s),* the *Covered Person*, and the case management agency, a treatment plan is developed and implemented. If the attending *Provider(s)/Practitioner(s)* and/or the *Covered Person* do not wish to follow the treatment plan as developed, then treatment and coverage of the patient's medical condition will continue uninterrupted and benefits will be paid as stated in the SHBP.

While large case management treatment usually contains treatment options covered under the terms of the SHBP, in some cases, the most appropriate and cost-effective care will be rendered in a setting or manner not normally covered under the terms of the SHBP. In such cases, all *Medically Necessary* aspects of the approved treatment will be covered under the terms of the SHBP. Any alternative care or treatment pro-

vided will not be considered as setting any precedent or creating any future liability with respect to that *Covered Person* or any other *Covered Persons*. Benefits provided under this section are subject to all other SHBP provisions.

Refer also to the provision for extra-contractual benefits provided in Section I, Establishment of SHBP

A. Covered Drugs

When all of the provisions of the SHBP are satisfied, the SHBP will provide benefits as specified in the Schedule of Benefits for the following *Medically Necessary* covered drugs, devices, and supplies:

(1) Federal Legend Drugs and State-Restricted Drugs;

(2) compounded medications of which at least one ingredient is a Legend Drug;

(3) insulin;

(4) oral, transdermal, intervaginal contraceptives (including devices and implants), or contraceptive injections;

(5) blood factors up to a maximum of three treatments per *Plan Year*;

(6) Legend smoking deterrents;

(7) Legend Vitamin B12 (all dosage forms);

(8) prenatal vitamins;

(9) anti-malarial drugs; and

(10) prescription oral fluoride products.

B. Dispensing Limits

The amount of any drug which may be dispensed per prescription or refill (regardless of the dosage form) is limited to a 90 day supply or 90 units, whichever is greater. Other dispensing limits may be imposed as required by federal or state regulation or for other reasons.

C. Excluded Drugs

Some items which are excluded under the Prescription Benefits and Exclusions may be Covered Medical Services as provided in Section VII of this Plan Document. Expenses for the following are not covered by the SHBP unless specifically listed as a covered benefit:

(1) drugs not classified as Federal Legend Drugs (i.e., over-the-counter drugs and products);

(2) non-systemic contraceptives;

(3) fertility drugs;

(4) impotency drugs, except when *Medically Necessary* for treatment of conditions other than sexual dysfunction;

(5) Legend vitamins;

(6) cosmetic drugs and drugs used to promote or stimulate hair growth;

(7) biologicals, immunization agents, or vaccines, except as specifically provided;

(8) drugs labeled "Caution – limited by federal law to *Investigational* use," or "*Experimental* drugs," even though a charge is made to the individual;

(9) any prescription refilled in excess of the number of refills specified by the ordering *Provider*/*Practitioner*, or any refill dispensed one year after the original order (as determined by the Plan Administrator, this provision may not apply, in whole or in part, to prescription benefits at UNH Health Services);

(10) medication dispensed in excess of the dispensing limits;

(11) medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made by the pharmacy or *Provider*/*Practitioner*;

(12) services or products that are determined by the SHBP as not being *Medically Necessary;*

(13) medications provided to an international *Student* in his or her home country; and

(14) any medication that would be excluded under Medical Benefit Exclusions, except as otherwise provided, stated in Section X.

D. Review of Prescription Drugs for Medical Necessity

All prescription drug charges are subject to review for *Medically Necessity* and for eligibility under the Prescription Benefits and Exclusions of the SHBP. This review process may require the SHBP-*Covered Person* to complete a claim form and submit it to the Claims Administrator.

A. Excluded Expenses

1. Expenses for services related to participation in UNH's NCAA-sanctioned intercollegiate sports. This exclusion does not include intramural or club sports.
2. Any treatment not resulting from an *Accident*, *Illness*, *Mental or Nervous Disorder, Substance Addiction/Abuse*, except covered Preventive Care as specified, or for any service or supply that is not specifically listed as a *Covered Expense* under Covered Medical Services in this Plan Document.
3. Treatment not prescribed or recommended by a *Provider/Practitioner*; services, supplies, or treatments which are not *Medically Necessary*; except covered Preventive Care as specified; and expenses for supplies that do not require a *Provider's/Practitioner's* prescription.
4. Surgical Charges are excluded for any service, care, procedure, or program for weight or appetite control, weight loss, weight management, nutritional, or dietary counseling (except as described herein), or for control of obesity even if the weight or obesity aggravates another condition, including but not limited to, gastric bypass, gastric stapling, balloon catheterization, liposuction, or reconstructive surgery. This exclusion applies regardless of whether there is a condition of *Morbid Obesity*.
5. Charges for which there is no legal obligation to pay, such as that portion of any charge which would not have been made if the patient did not have this coverage, or any charge for services or supplies which are normally furnished without charge.
6. *Experimental/Investigational* equipment, services, or supplies.
7. Charges for services, supplies, or treatment not recognized by the American Medical Association as generally accepted and *Medically Necessary* for the diagnosis and/or treatment of an active *Illness* or *Injury*; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value.
8. Charges for services rendered by a provider who is not a *Provider/Practitioner*.
9. Any condition, disability, or expense sustained as a result of being engaged in: an Illegal occupation; commission or attempted commission of an assault or other illegal act; intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime; participation in a civil revolution or a riot or a war, or act of war which is declared or undeclared.
10. Any condition or disability sustained as a result of being engaged in an activity primarily for wage, profit, or gain and that could entitle the *Covered Person* to a benefit under the Worker's Compensation Act or similar legislation.
11. Educational, vocational, or training services and supplies. This exclusion does not apply to treatment of diabetes or other specifically provided Preventive Care benefits.
12. Expenses for preparing medical reports, itemized bills, or claim forms; and mailing and/or shipping and handling expenses; and sales tax.
13. Expenses for broken appointments or telephone calls; and charges for drugs, medicines, services, or supplies prescribed by a physician (or any other medical practitioner) when such prescription is made only on the basis of an online or telephonic consultation not preceded by an in-person medical examination with that *Physician/ Practitioner*.
14. Services furnished by or for the United States government or any other government, unless payment is legally required; and Services or supplies furnished, paid for, or for

which benefits are provided or required by reason of past or present service of any covered family member in the armed forces of a government.

15. Travel expenses of a *Physician*/*Practitioner*; and travel expenses of a *Covered Person* other than local ambulance services to the nearest medical facility equipped to treat the *Illness* or *Injury*, except as specified.
16. Charges incurred outside of the United States, if the *Covered Person* traveled to such location for the purpose of obtaining medical services, drugs, or supplies.
17. *Custodial Care*.
18. Expenses for treatment, services, or supplies provided by a *Provider*/*Practitioner* who ordinarily resides with the *Covered Person*, or is the *Covered Person*, including but not limited to, his or her spouse, child, brother, sister, or parent.
19. Expenses used to satisfy plan deductibles, copayment, and/or coinsurance amounts.
20. *Expenses Incurred* for services rendered prior to the *Effective Date* of coverage under the SHBP or after coverage terminates, even though *Illness* or *Injury* started while coverage was in force and claims originally submitted to the Claims Administrator for the SHBP more than one year after the date on which the service or supply was incurred.
21. Personal comfort or service items while confined in a *Hospital*, such as, but not limited to, radio, television, telephone, and guest meals.
22. Charges incurred at a residential treatment facility, regardless of whether the service or supply is a *Covered Expense*.
23. Sex change surgery and penile prosthetic implants.
24. Diagnosis or treatment for the correction of *Infertility* (surgical or non-surgical), surgical impregnation procedures, reproductive sterilization, and reversal of any reproductive sterilization procedure.
25. Any refractive eye surgery or procedure designed to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including, but not limited to, LASIK, radial keratotomy, and keratomileusis surgery; and Eye examinations for diagnosis or treatment of a refractive error, including the fitting of eyeglasses or lenses, orthoptics, vision therapy, or supplies.
26. Services related to Dental or oral surgery, except as specifically provided, and charges for the treatment of Temporomandibular Joint Disorders (TMJ).
27. Charges for court-ordered treatment, or any treatment not initiated by a physician or covered provider of any kind, except psychiatric evaluations.
28. Expenses for treatment of behavioral problems, learning disabilities, or developmental delays when received without a medical diagnosis, including, but not limited to, Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), and Early Intervention (EI) services. This exclusion applies to the treatment of a condition; it does not apply to *Expenses Incurred* for the diagnosis of the condition.
29. Charges for services for, or related to, reconstructive surgery or cosmetic health services except as specifically provided. This exclusion does not apply to: reconstructive surgery for newborn children who are covered at the time of birth by the SHBP; reconstructive surgery related to an *Injury* or *Accident*, within one year of the *Injury* or *Accident* first occurring while covered under the SHBP; or reconstructive surgery of the breasts following a mastectomy, including: reconstructive surgery of the breast(s) on which the surgery was performed, reconstructive surgery of an unaffected breast to produce a symmetrical appearance, and expenses related to prostheses and physical complications at all stages of a mastectomy.

30. Orthognathic surgery.
31. Hearing examinations, hearing aids, or related supplies.
32. Adoption expenses; and Surrogate expenses.
33. Biofeedback, unless approved by the UNH Counseling Center.
34. Hypnosis.
35. Genetic counseling and testing.
36. Expenses for pastoral counseling, marriage therapy, music or art therapy (unless part of an inpatient program), assertiveness training, dream therapy, recreational therapy, stress management, or other supportive therapies; sex counseling; and massage therapy or Rolfing.
37. Expenses for growth hormones, unless pre-authorized by CIGNA.
38. *Expenses Incurred* for non-surgical treatment of the feet, including treatment of corns, calluses, and toenails, or other routine foot care, except as specifically provided.
39. 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, equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs, and any other clothing or equipment which could be used in the absence of an *Illness* or *Injury*.
40. Expenses exceeding the *Reasonable and Customary* charge for the geographic area in which services are rendered; and expenses for services and supplies in excess of SHBP limits or benefit maximums.

B. Pre-existing Condition Limitation

Unqualified Late Enrollees are subject to the following limitations.

(1) Pre-existing Condition

(a) A Pre-existing Condition is any medical condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended by or received from a *Provider*/*Practitioner* in the six (6) month period immediately preceding the *Covered Person's Effective Date* under this SHBP. However, pregnancy does not constitute a Pre-existing Condition for the purpose of this Section X (B).

(b) A condition will cease to be a Pre-existing Condition when a *Covered Person* has been enrolled, beginning with his/her *Effective Date* under the SHBP, for a period of six (6) consecutive months, subject to paragraph (e) below.

(c) Notwithstanding any other provision in the SHBP, the restriction in paragraph (b) above shall not apply to a newborn child, an adopted child under age 18, or a child under age 18 who has been placed for adoption with a *Covered Person* if that child becomes covered under the SHBP; any other group health plan; or any other *Creditable Coverage* within

thirty (30) days of birth, adoption, or placement for adoption, unless the child has a *Significant Break in Coverage*.

(d) The exclusion of benefits for a Pre-existing Condition described in paragraph (a) above shall not apply to a *Covered Person* who has resumed active participation in the SHBP immediately following a period of duty in the *Uniformed Service*, except with respect to a condition incurred by the *Covered Person*, or a condition that was aggravated, while the *Covered Person* was absent on duty in the *Uniformed Service*.

(e) Notwithstanding any other provision in the SHBP, any period during which benefits for a Pre-existing Condition described in paragraph (a) above otherwise would be excluded shall be reduced by the length of a *Covered Person's Creditable Coverage*, which is calculated by determining all days during which the *Covered Person* had one or more types of *Creditable Coverage*, without regard to specific benefits included in the coverage. However, the days of *Creditable Coverage* that occurred before a *Significant Break in Coverage* shall not be counted for the purpose of reducing any period of exclusion.

(2) Proof of Creditable Coverage

A *Covered Person* may prove *Creditable Coverage* by either of two methods.

(a) First, by presenting a written *Certificate of Coverage* from the source or entity that provided the coverage showing:

- the date the *Certificate* was issued;
- the name of the group health plan that provided the coverage;
- the name of the *Covered Person* to whom the *Certificate* applies;
- the name, address, and telephone number of the plan administrator or issuer providing the *Certificate*;
- a telephone number for further information (if different);
- either (1) a statement that the *Covered Person* has at least six (6) months of *Creditable Coverage*, not counting days of coverage before a *Significant Break in Coverage*, or (2) the date any waiting period (and affiliation period, if applicable) began and the date *Creditable Coverage* began; and
- the date *Creditable Coverage* ended, unless the *Certificate* indicates that coverage is continuing as of the date of the *Certificate*.

(b) Second, if the *Covered Person* for any reason is unable to obtain a *Certificate* from another plan, he/she may demonstrate *Creditable Coverage* by other evidence, including but not limited to, documents, records, third-party statements, or telephone calls by the SHBP to a third-party provider of medical services.

(3) Notice of Pre-existing Condition Exclusion

(a) If, within a reasonable time after receiving the information about *Creditable Coverage* described in Paragraph (2) above, this SHBP determines that an exclusion for Pre-existing Conditions applies, it will notify the *Covered Person* of that conclusion and will specify the source of any information on which it relied in reaching the determination. Such notification will also explain the SHBP's appeals procedures and give the *Covered Person* a reasonable opportunity to present additional evidence.

(b) If the SHBP later determines that a *Covered Person* did not have the claimed *Creditable Coverage*, the SHBP may modify its initial determination to the contrary. In that case, the *Covered Person* will be notified of the reconsideration; however, until a final determination is reached, the SHBP will act in accordance with its initial determination in favor of the *Covered Person* for the purpose of approving medical services.

(c) The SHBP will assist in obtaining a *Certificate* from any prior plan or issuer, if necessary.

A. Maximum Benefits under All Plans

If any *Covered Person* covered under the SHBP is also covered under one or more Other Plan(s), and the sum of the benefits payable under all the plans exceeds the *Covered Person's* eligible charges during any claim determination period, then the benefits payable under all the plans involved will not exceed the eligible charges for such period as determined under the SHBP. Benefits payable under another plan are included, whether or not a claim has been made. For these purposes,

(1) claim determination period means a *Plan Year*; and

(2) eligible charge means any necessary, *Reasonable and Customary* item of which at least a portion is covered under the SHBP, but does not include charges specifically excluded from benefits under the SHBP that may also be eligible under any Other Plans covering the *Covered Person* for whom the claim is made.

B. Other Plans

Other Plan means the following plans providing benefits or services for medical and dental care or treatment and include:

(1) group insurance or any other arrangement for coverage for *Covered Persons* in a group, whether on an insured or uninsured basis;

(2) Blue Cross, Blue Shield, or any other prepayment coverage, including health maintenance organizations (HMOs), *Medicare*, or Medicaid; or

(3) no-fault automobile insurance (for purposes of the SHBP, in states with compulsory no-fault automobile insurance laws, each *Covered Person* will be deemed to have full no-fault coverage to the maximum available in that state. The SHBP will coordinate benefits with no-fault coverage as defined in the state of residence, whether or not the *Covered Person* is in compliance with the law, or whether or not the maximum coverage is carried).

C. Determining Order of Payment

If a *Covered Person* is covered under two or more plans, the order in which benefits will be determined is as follows.

(1) The plan covering the *Covered Person* as a subscriber pays benefits first. The plan covering the *Covered Person* as an *Eligible Dependent* pays benefits second.

(2) If no plan is determined to have primary benefit payment responsibility under (1) above, then the plan that covered the *Covered Person* for the longest period has the primary responsibility.

(3) A plan that has no Coordination of Benefits provision will be deemed to have primary benefit payment responsibility.

(4) The plan covering the parent of the *Eligible Dependent* child pays first if the parent's birthday (month and day of birth, not year) falls earlier in the calendar year. The plan covering the parent of an *Eligible Dependent* child pays second if the parent's birthday falls later in the calendar year.

(5) In the event that the parents of the *Eligible Dependent* child are divorced or separated, the following order of benefit determination applies:

(a) the plan covering the parent with custody pays benefits first;

(b) if the parent with custody has not remarried, then the plan covering the parent without custody pays benefits second;

(c) if the parent with custody has remarried, then the plan covering the step-parent pays benefits second, and the plan covering the parent without custody pays benefits third; and

(d) if a divorce decree or other order of a court of competent jurisdiction places the financial responsibility for the child's health care expenses on one of the parents, then the plan covering that parent pays benefits first.

D. Facilitation of Coordination

For the purpose of Coordination of Benefits, the Claims Administrator:

(1) may release to, or obtain from, any other insurance company or other organization or individual any claim information, and any *Covered Person* claiming benefits under the SHBP must furnish any information that the Plan Administrator may require;

(2) may recover on behalf of the SHBP any benefit overpayment from any other individual, insurance company, or organization; and

(3) has the right to pay to any other organization an amount it will determine to be warranted, if payments that should have been made by the SHBP have been made by such organization.

A. Allocation of Authority

The Plan Administrator will control and manage the operation and administration of the SHBP. The Plan Administrator shall have the sole and exclusive right and discretion:

(1) to interpret the SHBP, the Plan Document, and any other writings affecting the establishment or operation of the SHBP, both as to legal import and as to the application of the provisions of any such documents to the facts of a particular claim for benefits, and to decide all matters arising under the SHBP, including the right to remedy possible ambiguities, inconsistencies, or omissions; and

(2) to make factual findings and decide conclusively all questions regarding any claim for benefits made under the SHBP.

All determinations of the Plan Administrator with respect to any matter relating to the administration of the SHBP will be conclusive and binding on all persons.

B. Powers and Duties of Plan Administrator

The Plan Administrator will have the following powers and duties:

(1) to require any person to furnish such reasonable information as the Plan Administrator may request for the proper administration of the SHBP as a condition to receiving any benefits under the SHBP;

(2) to make and enforce such rules and regulations and prescribe the use of such forms as the Plan Administrator will deem necessary for the efficient administration of the SHBP;

(3) to decide on questions concerning the SHBP, or the eligibility of any person to participate in the SHBP, in accordance with the provisions of the SHBP;

(4) to determine the amount of benefits that will be payable to any person in accordance with the provisions of the SHBP;

(5) to inform *Covered Person(s)*, as appropriate, of the amount of such benefits payable in accordance with the provisions of the SHBP;

(6) to provide a full and fair review to any *Covered Person* whose claim for benefits under the SHBP has been denied in whole or in part;

(7) to designate other persons to carry out any duty or power that would otherwise be a fiduciary or clerical responsibility of the Plan Administrator under the terms of the SHBP;

(8) to retain such actuaries, accountants, consultants, third-party administration services, legal counsel, or other specialists, as the Plan Administrator may deem appropriate and necessary for the SHBP's effective administration; and

(9) to perform any other functions or actions that would commonly be within the purview of a similarly situated administrator for a student health insurance/benefits plan.

C. Delegation by the Plan Administrator

The Plan Administrator may employ the services of such persons (including an insurance company or third party administrator) as it may deem necessary or desirable in connection with the administration of claims or other operations of the SHBP.

The Plan Administrator will also have the power and duty to retain the services of one or more health care professionals, for the purpose of reviewing benefit claims that are under appeal for reasons based on medical judgment, such as *Medical Necessity* or *Experimental* treatments.

The Plan Administrator (and any person to whom any duty or power in connection with the operation of the SHBP is delegated) may rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly-appointed actuary, accountant, consultant, third-party administration service, legal counsel, or other specialist, and the Plan Administrator or such delegate will be fully protected in respect to any action taken or permitted in good faith in reliance upon such table, valuations, certificates, etc.

D. Payment of Administrative Expenses

All reasonable costs incurred in the administration of the SHBP including, but not limited to, administrative fees and expenses owed to any third-party administrative service, actuary, consultant, accountant, specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, will be paid by the Plan Sponsor unless the Plan Administrator directs the SHBP to pay such expenses and such payment by the SHBP is permitted by law.

E. Fiduciary Liability

To the extent permitted by law, neither the Plan Administrator nor any other entity or person will incur any liability for any acts or failure to act.

A. Termination Events

The coverage of any *Covered Person* shall automatically cease immediately upon the earliest day indicated below:

(1) on the day in which the *Covered Person* ceases to be in a class of eligible *Students* or *Eligible Dependents* (except in the case of a *Student* who is withdraws from UNH after the date in a *Coverage Period* when no portion of the student's tuition/fee billing is refunded by the University – see Section IV(A);

(2) on the day in which the Plan Administrator terminates the *Covered Person's* coverage;

(3) on the day the SHBP terminates;

(4) on the day in which the *Covered Person* dies;

(5) on the day in which the *Covered Person* enters service in the *Uniformed Services* on an active-duty basis;

(6) on the day an international *Student* withdraws from UNH or the day an international *Student* receives an approved medical withdrawal from UNH and leaves the United States; or

(7) at the end of the *Plan Year* for a spouse who is divorced from a *Covered Student* during the *Plan Year*.

The coverage of an *Eligible Dependent* who has attained the maximum age limit shall not terminate if such *Eligible Dependent* is permanently and *Totally Disabled* (as defined in Internal Revenue Code section 22(e) (B) and in Section XVIII of this Plan Document, entitled Definitions), at any time during the calendar year in which the taxable year of the *Covered Student* begins. Written proof of such *Eligible Dependent's* permanent and *Total Disability* must be submitted on an annual basis to the Plan Administrator, and the Plan Administrator reserves the right to require, at its expense, an independent medical, psychiatric, or psychological evaluation or examination in connection with any such annual review of such *Eligible Dependent's* disability status.

B. Certificate of Creditable Coverage

As mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the SHBP will provide a *Certificate of Coverage* to any *Covered Person* after the *Covered Student* loses coverage under the SHBP. In addition, a *Certificate* will be provided upon request, if the request is made within twenty-four (24) months after the *Covered Student* loses coverage under the SHBP. In that case, the *Certificate* will be provided at the earliest time that the SHBP, acting in a reasonable and prompt fashion, can furnish said *Certificate*.

The SHBP will make reasonable efforts to locate and provide *Certificates of Coverage* with respect to *Eligible Dependents*. However, although the SHBP will make reasonable efforts to collect information applicable to any *Eligible Dependents* of the *Covered Student* and to include that information on the *Certificate*, the SHBP will not issue an automatic *Certificate* for *Eligible Dependents* until the SHBP has reason to know that an *Eligible Dependent* has lost coverage under the SHBP.

C. Medical Leave of Absence

Any full-time *Student* enrolled in the SHBP who, as a result of an *Injury* or *Illness*, is *Totally Disabled*, will be eligible to continue coverage under the SHBP for himself/herself (and for his/her *Eligible Dependents* who are enrolled in the SHBP at the time the medical leave commences) subject to the payment of the necessary contributions required under the SHBP. The continuation of coverage is only for the *Plan Year* that the student is enrolled when the Medical Leave of Absence is approved by the Plan Sponsor. Continuation of Coverage does not continue beyond this *Plan Year*.
Certification of the medical leave of absence must be made by the *Student's Provider*/*Practitioner* and such certification must be presented to and approved by the Plan Administrator. The Medical Leave of Absence cannot extend beyond end of the Plan Year in which the Medical Leave of Absence is granted. Refer also to Termination Events for international *Student*s who leave the United States.

For the purpose of this Medical Leave of Absence provision, full-time *Student* status is defined by the Registrar for UNH for each class of *Students*.

D. Continuation of Coverage

Except as provided in Section C, Medical Leave of Absence, the SHBP does not offer Continuation of Coverage in the event a *Covered Person* loses coverage under the SHBP. The SHBP is not subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) affords protection to patients from unwarranted disclosure of private medical information by specifying those situations in which, and those persons to whom, personal information may be disclosed.

A. Permitted Disclosures

There are three circumstances under which the SHBP may disclose an individual's protected health information to the Plan Sponsor.

(1) The SHBP may inform the Plan Sponsor whether an individual is enrolled in the SHBP.

(2) The SHBP may disclose summary health information to the Plan Sponsor. The Plan Sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the SHBP. Summary health information is information that summarizes claims history, claims expenses, and/or types of claims without identifying the individual.

(3) The SHBP may disclose an individual's protected health information to the Plan Sponsor for SHBP administrative purposes. This is because the Plan Sponsor performs many of the administrative functions necessary for the management and operation of the SHBP. The Plan Sponsor has certified to the SHBP that the SHBP's terms have been amended to incorporate the terms of this summary. The Plan Sponsor has agreed to abide by the terms of this summary. The SHBP's privacy notice also permits the SHBP to disclose an individual's protected health information to the Plan Sponsor as described in this summary.

B. Restrictions on Plan Administrator and Disclosure

The restrictions that apply to the Plan Sponsor's use and disclosure of an individual's protected health information are as follows:

(1) The Plan Sponsor will only use or disclose an individual's protected health information for SHBP administrative purposes, as required by law, or as permitted under HIPAA regulations. (Refer to SHBP's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.)

(2) If the Plan Sponsor discloses any of an individual's protected health information to any of its agents or subcontractors, the Plan Sponsor will require the agent or subcontractor to keep an individual's protected health information confidential as required by the HIPAA regulations.

(3) The Plan Sponsor will not use or disclose an individual's protected health information for UNH admissions-related or employment-related actions or de-

cisions or in connection with any other benefit or benefit plan of the Plan Sponsor unless permitted under HIPAA.

(4) The Plan Sponsor will promptly report to the SHBP any use or disclosure of an individual's protected health information that is inconsistent with the uses or disclosures allowed in this summary.

(5) The Plan Sponsor will allow an individual or the SHBP to inspect and copy any protected health information about that individual who is in the Plan Sponsor's custody and control. The HIPAA Regulations set forth the rules that an individual and the SHBP must follow in this regard. There are some exceptions to this provision allowed under federal regulations.

(6) The Plan Sponsor will amend, or allow the SHBP to amend, any portion of an individual's protected health information to the extent permitted or required under the HIPAA Regulations.

(7) With respect to some types of disclosures, the Plan Sponsor will keep a disclosure log for a period of not less than six (6) years. An individual has a right to see the disclosure log. The Plan Sponsor does not have to maintain the log if disclosures are for certain SHBP-related purposes, such as payment of benefits or health care operations.

(8) The Plan Sponsor will make its internal practices, books, and records relating to its use and disclosure of an individual's protected health information available to the SHBP and to the U.S. Department of Health and Human Services.

(9) The Plan Sponsor will, if feasible, return or destroy all of an individual's protected health information in the Plan Sponsor's custody or control that the Plan Sponsor has received from the SHBP or from any business partner, agent, or subcontractor when the Plan Sponsor no longer needs an individual's protected health information to administer the SHBP. If it is not feasible for the Plan Sponsor to return or destroy an individual's protected health information, the Plan Sponsor will limit the use or disclosure of such protected health information.

C. Authorized Recipients of Protected Health Information

The following classes of individuals or other workforce members under the control of the Plan Sponsor may be given access to an individual's protected health information on a need-to-know basis, solely for the purposes set forth above:

(1) Director of Finance and Administration, Health Services, UNH;

(2) Chair of the Student Health Insurance Advisory Committee;

(3) Executive Director for Health Services, UNH;
(4) Professional staff and/or clinicians or counselors of UNH Health Services and Counseling Center, and
(5) Consultants or other third parties retained by the Plan Sponsor to perform duties necessary for the function of the SHBP.

This list includes every class of individuals or other workforce members under the control of the Plan Sponsor who may receive an individual's protected health information. If any of these individuals or workforce members use or disclose an individual's protected health information in violation of the rules that are set out in this summary, the responsible individual(s) or workforce member(s) will be subject to disciplinary action and sanctions. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to the SHBP and will cooperate with the SHBP to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to the individual.

D. Security Provisions

The Plan Sponsor will receive or generate electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the Plan Sponsor certifies to the SHBP that it agrees to:

(1) take appropriate and reasonable safeguards (administrative, physical, and technical) to protect the confidentiality, integrity, and availability of the information it creates, receives, maintains, or transmits;

(2) require that any agent or subcontractor of the Plan Sponsor agrees to the same requirements that apply to the Plan Sponsor under this provision;

(3) report to the SHBP any security incident of which the Plan Sponsor becomes aware; and

(4) apply reasonable and appropriate security measures to maintain adequate separation between the SHBP and Plan Sponsor.

A. Payment Condition

(1) The SHBP may elect, but is not required, to conditionally advance payment of medical benefits in those situations where an *Injury, Illness*, disease, or disability is caused, in whole or in part, by, or results from, the acts or omissions of a third party, or the acts or omissions of a *Covered Person* ("SHBP Beneficiary") where any insurance coverage, no-fault, uninsured motorist, underinsured motorist, medical payment provision, or other insurance policies or funds ("Coverage") is available.

(2) A SHBP Beneficiary, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees, by acceptance of the SHBP's payment of medical benefits, to maintain one hundred percent (100%) of the SHBP's payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust and without dissipation except for reimbursement to the SHBP or its assignee. By accepting benefits under the SHBP, the SHBP Beneficiary recognizes the property right or equitable interest of the SHBP in any cause of action the SHBP Beneficiary may have and the proceeds thereof.

(3) In the event a SHBP Beneficiary settles, recovers, or is reimbursed by any third party or Coverage, the SHBP Beneficiary agrees to reimburse the SHBP for all benefits paid or that will be paid. The SHBP Beneficiary acknowledges that the SHBP has the first priority right of recovery and a first lien to the extent of benefits provided by the SHBP. If the SHBP Beneficiary fails to reimburse the SHBP for all benefits paid or to be paid out of any judgment or settlement received, the SHBP Beneficiary will be responsible for any and all expenses (fees and costs) employed with the SHBP's attempt to recover such money from the SHBP Beneficiary.

B. Subrogation

(1) As a condition to participating in and receiving benefits under this SHBP, the SHBP Beneficiary agrees to subrogate the SHBP to any and all claims, causes of action or rights that may arise against any person, corporation, and/or entity, and to any Coverage for which the SHBP Beneficiary claims an entitlement, regardless of how classified or characterized. The SHBP Beneficiary agrees to reimburse the SHBP for any such benefits paid when judgment or settlement is made.

(2) If the SHBP Beneficiary decides to pursue a third party or any Coverage available as a result of the said *Injury* or condition, the SHBP Beneficiary agrees to include the SHBP's subrogation claim in that action. If there is a failure to do so, the SHBP will be legally presumed to be included in such action.

(3) The SHBP may, in its own name or in the name of the SHBP Beneficiary or their personal representative, commence a proceeding or pursue a claim against such other third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or payments advanced by the SHBP.

(4) The SHBP Beneficiary then authorizes the SHBP to pursue, sue, compromise, or settle any such claims in their name and agrees to cooperate fully with the SHBP in the prosecution of any such claims.* This includes the failure of the SHBP Beneficiary to file a claim or pursue damages against:

(a) the responsible party, their insurer, or any other source on behalf of that party;

(b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, or uninsured or underinsured motorist coverage;

(c) any policy of insurance from any insurance company or guarantor of a third party;

(d) any worker's compensation or other liability insurance company; or

(e) any other source, including but not limited to, crime victim restitution funds, any medical, disability, or other benefit payments, and school insurance coverage.

* The SHBP Beneficiary, his or her guardian, or the estate of a SHBP Beneficiary, assigns all rights to the SHBP or its assignee to pursue a claim and the recovery of all expenses from any sources listed above.

C. Right of Reimbursement

(1) The SHBP shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs, or application of the common fund doctrine, the make whole doctrine, the Rimes Doctrine, or any other similar legal theory, and without regard to whether the SHBP Beneficiary is fully compensated by his/her net recovery from all sources. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the SHBP Beneficiary's recovery is less than the benefits paid, then the SHBP is entitled to be paid all of the recovery achieved.

(2) The SHBP will not be responsible for any expenses, attorney fees, costs, or other monies incurred by the attorney for the SHBP Beneficiary or his/her beneficiaries, commonly known as the common fund doctrine. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of a litigious nature may be deducted from the SHBP's recovery without the prior expressed written consent of the SHBP.

(3) Furthermore, it is prohibited for the SHBP Beneficiary to settle a claim against a third party or any available coverage for certain elements of damages, but eliminating damages relating to medical *Expenses Incurred*.

(4) The SHBP's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the SHBP Beneficiary, whether under the doctrines of causation, comparative fault, or contributory negligence, or any other similar doctrine in law. Accordingly, any so-called "lien reduction statutes" which attempt to apply such laws and reduce a subrogating SHBP's recovery for any reason, will not be applicable to the SHBP and will not reduce the SHBP's subrogation recovery.

(5) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the SHBP and signed by the SHBP Beneficiary.

(6) This provision shall not limit any other remedies of the SHBP provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable *Illness, Injury*, disease, or disability.

D. Excess Insurance

If at the time of *Injury, Illness*, disease, or disability there is available, or potentially available, based on information known or provided to the SHBP or to the SHBP Beneficiary any other Coverage including, but not limited to, judgment at law or settlements, the benefits under this SHBP shall apply only as excess insurance over such other sources of indemnification. The SHBP's benefits shall be excess to:

(1) the responsible party, their insurer, or any other source on behalf of that party;

(2) any first party insurance through medical payment coverage, personal injury protection, no-fault insurance, or uninsured or underinsured motorist coverage;

(3) any policy of insurance from any insurance company or guarantor of a third party;

(4) any worker's compensation or other liability insurance company; and

(5) any other source including, but not limited to, crime victim restitution funds, any medical, disability, or other benefit payments, and school insurance coverage.

E. Wrongful Death Claims

In the event that the SHBP Beneficiary dies as a result of his or her *Injuries* and a wrongful death or survivor claim is asserted against a third party or any Coverage under the laws of any state, the SHBP's subrogation and reimbursement rights still apply.

F. Obligations

(1) It is the SHBP Beneficiary's obligation to:

(a) cooperate with the SHBP, or any representatives of the SHBP, in protecting its rights of subrogation and reimbursement, including completing discovery, attending depositions, and/or attending or cooperating in a trial in order to preserve the SHBP's subrogation rights;

(b) provide the SHBP with pertinent information regarding the *Injury*, including accident reports, settlement information, and any other requested additional information;

(c) take such action and execute such documents as the SHBP may require to facilitate enforcement of its subrogation and reimbursement rights;

(d) do nothing to prejudice the SHBP's rights of subrogation and reimbursement;

(e) promptly reimburse the SHBP when a recovery through settlement, judgment, award, or other payment is received;

(f) not settle, without the prior consent of the SHBP, any claim that the SHBP Beneficiary may have against any legally-responsible party or insurance carrier; and

(g) refrain from releasing any party, person, corporation, entity, insurance company, or insurance policies or funds that may be responsible for or obligated to the SHBP Beneficiary for the *Injury* or condition without obtaining the SHBP's written approval.

(5) Failure to comply with any of these requirements by the SHBP Beneficiary, his or her attorney or guardian may, at the SHBP's discretion, result in a forfeiture of payment by the SHBP of medical benefits, and any funds or payments due under this SHBP may be withheld to satisfy the SHBP Beneficiary's obligation. If the SHBP Beneficiary fails to reimburse the SHBP for all benefits paid or to be paid, as a result of said *Injury* or condition, out of any judgment or settlement received, the SHBP Beneficiary will be responsible for any and all expenses (whether fees or costs) incurred with the SHBP's attempt to recover such money from the SHBP Beneficiary.

G. Minor Status

(1) In the event the SHBP Beneficiary is a minor, as that term is defined by applicable law, the minor's parent(s) or court-appointed guardian shall cooperate in any and all actions requested by the SHBP to seek and obtain any requisite court approval in order to bind the minor and his or her estate insofar as the subrogation and reimbursement provisions are concerned.

(2) If the minor's parent(s) or court-appointed guardian fail or refuse to take such action, the SHBP shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees incurred with obtaining such approval shall be paid by the minor's parent(s) or court-appointed guardian.

H. Language Interpretation

The Plan Administrator retains sole, full, and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the SHBP's subrogation and reimbursement rights. The Plan Administrator may amend the SHBP at anytime without prior notice.

I. Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and the SHBP. The affected section shall be fully severable. The SHBP shall be construed and enforced as if such invalid or illegal sections had never been inserted in the SHBP.

A. Amendment

The Plan Administrator has the right to amend this SHBP in any and all respects at any time, and from time to time, without prior notice. Any such amendment will be by a written instrument signed by a duly-authorized Officer of the Plan Sponsor. The Plan Administrator will notify all *Covered Persons* of any amendment modifying the material terms of the SHBP as soon as is administratively feasible after its adoption.

B. Termination of SHBP

Regardless of any other provision of the SHBP, the Plan Sponsor reserves the right to terminate the SHBP at any time without prior notice. Such termination will be evidenced by a written resolution of the Plan Sponsor. The Plan Administrator will provide notice of the SHBP's termination as soon as administratively feasible.

A. Plan Funding

All benefits paid under the SHBP shall be paid in cash from the designated SHBP fund established and maintained by the Plan Sponsor. No person shall have any right or title to, or interest in, any investment reserves, accounts, or funds that UNH may purchase, establish, or accumulate to aid in providing benefits under the SHBP. No person shall acquire any interest greater than that of an unsecured creditor.

B. In General

Any and all rights provided to any *Covered Person* under the SHBP shall be subject to the terms and conditions of the SHBP. This Plan Document shall not constitute a contract between the Plan Sponsor and any *Covered Person,* nor shall it be consideration or an inducement for the initial or continued enrollment of any *Student* in UNH. Likewise, maintenance of this SHBP shall not be construed to give any *Covered Person* the right to be retained as a *Covered Person* by the Plan Sponsor or the right to any benefits not specifically provided by the SHBP.

C. Waiver and Estoppel

No term, condition, or provision of the SHBP shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the SHBP, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived, and it shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No *Covered Person* or eligible beneficiary other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

D. Non-Vested Benefits

Nothing in the SHBP shall be construed as creating any vested rights to benefits in favor of any *Covered Person*.

E. Interests Not Transferable

The interests of the *Covered Student* and their *Eligible Dependents* under the SHBP are not subject to the claim of their creditors and may not be voluntarily or involuntarily transferred, alienated, or encumbered without the written consent of the Plan Administrator.

F. Severability

If any provision of the SHBP shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the SHBP, but the SHBP shall be construed and enforced as if the invalid or illegal provision had never been inserted.

The Plan Sponsor shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the SHBP.

G. Headings

All section headings in this Plan Document have been inserted for convenience only and shall not determine the meaning of the content thereof.

The following words and phrases will have the following meanings when used in the within this Plan Document, unless a different meaning is plainly required by the context.

Accident/Accidental – means a sudden or unforeseen event which:

(1) causes *Injury* to the physical structure of the body;

(2) results from an external agent of trauma;

(3) is definite as to time and place; and

(4) may happen involuntarily and entail unforeseen consequences or may be the result of an intentional self-inflicted injury and entail foreseeable consequences.

An *Accident* does not include harm resulting from a disease or sickness and will be determined by the Claims Administrator.

Adverse Determination – means:

(1) the requested benefit is denied, reduced, or terminated, or payment is not made, in whole or in part, for the benefit because a determination was made by the Claims Administrator that, based upon the information provided, the request for benefit under the SHBP does not meet the requirements for *Medical Necessity*, appropriateness, health care setting, level of care or effectiveness, or is determined to be experimental or investigational;

(2) the denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by the Claims Administrator of your ineligibility to participate in the SHBP;

(3) any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment in whole or in part for a benefit; or

(4) a rescission of coverage determination.

Alcoholism – means an alcohol-induced disorder which produces a state of psychological and/or physical dependence.

Ambulatory Surgical Center – means a specialized facility:

(1) where coverage of services performed at such a facility is mandated by law, and such facility has been licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located; or

(2) where coverage of services performed at such a facility is not mandated by law and meets all of the following requirements.

(a) It is established, equipped, and operated in accordance with the applicable laws in the jurisdiction in which it is located primarily for the purpose of performing surgical procedures.

(b) It is operated under the supervision of a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is devoting full-time to such supervision and permits a surgical procedure to be performed only by a duly-qualified *Provider*/*Practitioner* who, at the time the procedure is performed, is privileged to perform such procedure in at least one *Hospital* (as defined) in the area.

(c) It requires in all cases (other than those requiring only local infiltration anesthetics) that a licensed anesthesiologist or licensed *Practitioner*/*Provider* qualified to administer anesthesia, administers the anesthetics and remains present throughout the surgical procedure.

(d) It provides at least two operating rooms and at least one post-anesthesia recovery room; is equipped to perform diagnostic X-ray and laboratory examinations; has trained personnel and necessary equipment and supplies available to handle foreseeable emergencies; and has such equipment and supplies including but not limited to, a defibrillator, a tracheotomy set, and a blood bank or other blood supply.

(e) It provides the full-time services of one or more Registered Nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room.

(f) It maintains a written agreement with at least one *Hospital* in the area for immediate acceptance of patients who develop complications or require post-operative or post-treatment confinement.

(g) It maintains an adequate medical record for each patient, and such record shall contain an admitting diagnosis, and, for all patients except those undergoing a procedure under local anesthesia, a pre-operative examination report, medical history, laboratory tests and/or X-rays, an operative report, and a discharge summary.

Annual Open Enrollment Period – means the period of time at the beginning of each *Plan Year* under policies determined and published by the Plan Administrator, during which *Students* may elect to enroll in the SHBP. *Students* first enrolling at UNH at periods other than the beginning of a *Plan Year* may also enroll in the SHBP under policies determined and published by the Plan Administrator. *Students* who waive enrollment in the SHBP cannot change their election until the next *Annual Open Enrollment Period*. *Students* who attain other health insurance that would qualify for waiving SHBP coverage may apply to withdraw from the SHBP at the end of any semester *Coverage Period*.

Biologically-Based Mental Illness – means a *Mental or Nervous Disorder* that is caused by a biological disorder of the brain and results in a clinically-significant or psychological syndrome or pattern that substantially limits the functioning of the person with the *Illness,* including, but not limited to, psychotic disorders (including schizophrenia), schizoaffective disorder, dissociative disorders, major depressive disorder, bipolar disorder, pervasive developmental disorders (autism, paranoia, panic disorder, obsessive-compulsive disorder), mood disorders, anxiety disorders, personality disorders, paraphilias disorders, attention deficit and disruptive behavior disorders, tic disorders, and eating disorders.

Birthing Center – means a facility operated primarily for the purpose of providing treatment for obstetrical care for which it was duly incorporated as a *Birthing Center* and registered as a *Birthing Center* with the existing state. The *Birthing Center* must also be licensed, if required by law.

Certificate/Certificate of Coverage – means a written certification provided by any source that offers medical coverage, including the SHBP, for purposes of confirming the duration and type of a *Covered Person's Creditable Coverage*.

Congenital Condition(s) – means a condition existing since birth, regardless of whether the condition is diagnosed or treated and whether the condition is inherited or caused by environmental factors.

Coverage Period – means the various periods during which benefits provided under this Plan are available to a *Covered Person*.

Covered Expense(s) – means the fee schedule amount for *In-Network Provider(s)/Practitioner(s)* or the *Reasonable and Customary Charge* for *Out-of-Network Provider(s)/Practitioner(s)* for services or supplies provided for *Medically Necessary* treatment of an *Illness* or *Injury*. *Covered Expenses* may be subject to copayments, the annual *Plan Year* deductible, and/or coinsurance as are stated in Section V of this Plan Document entitled Schedule of Benefits.

Covered Person – means a *Student* or *Eligible Dependent* enrolled in this SHBP.

Covered Student – means any *Student* who enrolls in the SHBP and signs the enrollment application form on behalf of himself or herself, and on behalf of any *Eligible Dependents*, and pays the necessary contributions under the SHBP. *Covered Student* also means those *Students* who are automatically enrolled in the SHBP and pay the necessary contributions under the SHBP.

Creditable Coverage – means coverage a *Covered Person* had under any of the following sources: A group health plan, health insurance coverage, *Medicare*, Medicaid, medical and dental care for members and former members of the *Uniformed Services*, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide

medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Subscribers Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act of 1961, as amended.

Custodial Care – means care which is designed essentially to assist the *Covered Person*, whether disabled or not, in meeting the activities of daily living, including services which constitute personal care such as help in walking and getting in or out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision over medication which can normally be self-administered. Such services and supplies are deemed to be *Custodial Care* whenever and wherever furnished, without respect to the *Provider*/*Practitioner* by whom or by which they are prescribed, recommended, or performed.

Day Treatment – means mental health or *Substance Addiction*/*Abuse* care on an individual or group basis for more than 2 hours but less than 24 hours per day in either a licensed *Hospital*, rural health center, community mental health center or *Substance Addiction*/*Abuse* treatment facility. This type of care is also referred to as partial hospitalization.

Durham Area – means geographic areas that have "038" in the first three digits of their U.S. Postal zip code.

Effective Date – means either the first day of the *Plan Year* or the first date of any *Coverage Period*. The *Effective Date* may be earlier than the first day of the *Plan Year* under certain circumstances established by UNH and published in this Plan Document or subsequent amendment. For Qualified Late Enrollees and newly acquired dependents, the *Effective Date* will be the first date of the month for SHBP coverage, unless otherwise specified in this Plan Document.

Effective Treatment of Alcoholism/Substance Addiction/Abuse – is a program of *Alcoholism*/ *Substance Addiction*/*Abuse* therapy that meets all of the following requirements.

(1) It is prescribed and supervised by a qualified *Provider*/*Practitioner*.

(2) The *Provider*/*Practitioner* certifies that a follow-up program has been established which includes therapy by a *Provider*/*Practitioner*, or group therapy under a *Provider's/Practitioner's* direction at least once per month.

(3) It includes attendance at least twice a month at meetings of organizations devoted to the therapeutic treatment of *Alcoholism*/*Substance Addiction*/*Abuse*.

Treatment for maintenance care is not considered *Effective Treatment*. Maintenance care consists of the providing of an environment without access to alcohol or drugs.

Eligible Dependent(s) – means person(s) eligible for coverage under the SHBP as a dependent of a *Covered Student* as defined in Section IV of this Plan Document, entitled SHBP Eligibility.

Emergency/Emergency Care/Emergency Medical Condition – means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

Examples of emergency care situations include, but are not limited to, symptoms of heart attack and stroke, poisoning, loss of consciousness, loss of breath, shock, severe bleeding, or convulsions. Emergency care does not include ambulance service to the facility where treatment is received (see Ambulance Services in Section V: Schedule of Benefits, and Section VIII: Preadmission/ Precertification).

Emergency Medical Services – means, with respect to an *Emergency Medical Condition*:

(1) a medical screening examination that is within the capability of the emergency department of a *Hospital*, including services routinely available to the emergency department, to evaluate such *Emergency Medical Conditions*; and

(2) such additional medical examination and treatment necessary to stabilize a patient.

ERISA **–** means the Employee Retirement Income Security Act of 1974, as amended.

Expenses Incurred – means an *Expense Incurred* at the time the service or supply is provided.

Experimental/Investigational – means a drug, device, medical treatment, new technology, procedure, or supply, which is not recognized as a *Covered Expense* as follows:

(1) The drug cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug, device, treatment, new technology, procedure, or supply is furnished.

(2) The drug, device, medical treatment, new technology, procedure, or supply, or the patient's informed consent document utilized with the drug, device, treatment, new technology, procedure, or supply, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval.

(3) Reliable evidence shows that the drug, device, medical treatment, new technology, procedure, or supply is the subject of on-going Phase I or Phase II clinical trials; is

the research, experimental study, or investigational arm of on-going Phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis.

(4) Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, new technology, procedure, or supply is that further studies or clinical trials are necessary to determine maximum tolerated dose, toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, new technology, procedure, or supply; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, new technology, procedure, or supply.

Emergency Evacuation – means after being treated at a local *Hospital*; the *Covered Person's* medical condition warrants transportation to his/her home country or permanent residence to obtain further medical treatment to recover from an *Illness* or *Injury* sustained while covered under the SHBP.

Freestanding Health Clinic – means a private facility other than a private office of a *Provider*/*Practitioner*, which is operated primarily for the purpose of providing the treatment of *Illness* or minor *Injuries* of patients who are treated with or without an appointment for which it is duly licensed.

Grievance – means a written or oral complaint submitted by you, or on your behalf, regarding:

(1) availability, delivery or quality of health care services, including a complaint regarding an Adverse Determination; or

(2) claims payment, handling or reimbursement for health care services; or

(3) matters pertaining to the relationship between you and the Claims Administrator.

Home Health/Hospice – means care provided by a *Home Health Care*/*Hospice Care Agency* under an approved *Home Health Plan*/*Hospice Plan of Care*. *Home Health*/*Hospice* also means a licensed *Home Health Care*/*Hospice Care Agency* or *Inpatient Hospice Facility* that meets all of the requirements specified in this Plan Document.

Home Health Care Agency/Hospice Care Agency – means an agency or organization which fully meets each of the following requirements.

(1) It is primarily engaged in and is duly licensed, if such licensing is required, by the appropriate licensing authority to provide *Skilled Nursing* services and other therapeutic services.

(2) It has policies established by a professional group employed with the agency or organization. The professional group must include at least one *Provider/ Practitioner* and at least one Registered Nurse (R.N.) to govern the services provided and it must provide for full-time supervision of such services by a *Provider*/*Practitioner* or Registered Nurse.

(3) It maintains a complete medical record on each patient.

(4) It has an administrator.

Home Health Plan/Hospice Plan of Care – means a prearranged, written outline of care that will be provided for the palliation and management of a person's terminal *Illness* or *Home Health* care services.

Hospital – means any institution which fully meets all of the following requirements.

(1) It must furnish day and night lodging.

(2) It must be primarily engaged in providing diagnostic and therapeutic facilities for surgical and medical diagnosis, and treatment and care of injured and sick persons by or under the supervision of physicians who are legally licensed to practice medicine for compensation from its patients on an inpatient basis,

(3) It must regularly and continuously provide day and night nursing service by or under the supervision of a *Provider*/*Practitioner*.

(4) It must not be, other than incidentally, a place for the aged or a nursing or convalescent home.

(5) It must be operated in accordance with the laws of the jurisdiction in which it is located.

The term *Hospital* includes an institution specializing in the care and treatment for rehabilitation and *Mental or Nervous Disorder,* emotional *Illness,* or disturbance, which would qualify under this definition as a *Hospital*. The term *Hospital* also includes a residential treatment facility specializing in the care and treatment of *Alcoholism*, drug addiction, or chemical dependency, provided such facility is duly licensed, if licensing is required by law in the jurisdiction where it is located, or otherwise lawfully operated if such licensing is not required.

The term *Hospital* also includes a rehabilitation facility/*Hospital* which is licensed by the State, accredited by the Joint Commission on Accreditation of Health Care Organizations, and accredited by the Commission of Accreditation of Rehabilitation Facilities.

Illness(es) – means a sickness, bodily disorder, disease, or *Mental or Nervous Disorder*. An *Illness* due to causes which are the same as or related to causes of a prior *Illness*, from which there has not been complete recovery will be considered a continuation of such prior *Illness*. The term *Illness* as used in this SHBP will include pregnancy, childbirth, miscarriage, termination of pregnancy, and any complications of pregnancy and related medical conditions.

Incurred Date – means the date the service was performed or the supply was provided.

Infertility – means the condition of a presumably healthy individual who is unable to conceive or produce conception during a one-year period.

Injury(ies) – means an *Accidental* bodily harm, damage, or trauma, which results independently of an *Illness,* and which will include all *Injuries* resulting from an *Accident* and all complications arising from such *Injuries* or *Accidents*.

Inquiry – means any communication to the Claims Administrator, Plan Administrator, or Case Management Service, or utilization review organization by you, or on your behalf, that has not been the subject of an *Adverse Determination* and that requests redress of an action, omission, or policy of the SHBP.

In-Network Provider(s)/Practitioner(s) – means an individual *Provider*/*Practitioner,* an organization of *Provider(s)*/*Practitioner(s)*, *Hospitals* and other health care *Provider(s)*/*Practitioner(s)* that have agreed to participate in the Preferred Provider Networks offered under the SHBP. The level of coverage for benefits within the network is generally greater than the level of coverage for benefits outside the network.

Inpatient Hospice Facility – means an establishment which may or may not be part of a *Hospital* and which meets all of the following requirements.

(1) It complies with licensing and other legal requirements in the jurisdiction where it is located.

(2) It is mainly engaged in providing inpatient palliative care for the terminally-ill on a 24-hour basis under the supervision of a *Provider*/*Practitioner* or by a Registered Nurse (R.N.) if the care is not supervised by a *Provider*/*Practitioner* available on a prearranged basis.

(3) It provides pre-death and bereavement counseling.

(4) It maintains clinical records on all terminally-ill persons.

(5) It is not mainly a place for the aged or a nursing or convalescent home.

Inpatient Hospice Facility also will include a *Hospice* facility approved for a payment of *Medicare Hospice* benefits.

Intensive Care Unit – means an accommodation of part of a *Hospital*, other than a postoperative recovery room, which, in addition to providing room and board:

(1) is established by the *Hospital* for a formal *Intensive Care Unit* program;

(2) is exclusively reserved for critically-ill patients requiring constant audio-visual observation prescribed by a *Provider*/*Practitioner* and performed by a *Provider*/*Practitioner* or by a specially-trained Registered Nurse; and

(3) provides all necessary life-saving equipment, drugs, and supplies in the immediate vicinity on a standby basis.

Internal Inquiry Process – means a process, prior to the *Grievance* process, during which the Claims Administrator attempts to answer and/or resolve concerns communicated by you or on your behalf. If the Claims Administrator fails to answer your questions or resolve your concerns to your satisfaction within three (3) business days, you have the option to proceed to the Internal Grievance Process provided in subsection B of Section XIX, Procedures/Statement of Rights.

Involuntarily Lose / Involuntary Loss – means, as this term is used for the purposes of administering the provisions for Qualified Late Enrollees, the involuntary loss of a group health insurance program for any reasons other than (a) non-payment of premium or (b) loss of health insurance because of withdrawal from UNH and with corresponding loss of eligibility status used to qualify for a parent's group health insurance plan. UNH reserves the right to exclude from this definition losses of group health insurance coverage which the *Covered Person* could have reasonably been expected to avoid.

IRO – means an Independent Review Organization**.** Refer to Section XIX, Inquiry, Grievance, and Appeals Process.

Medical Necessity/Medically Necessary – means a service or supply only when it meets all of the following requirements:

(1) It must be legal.

(2) It must be ordered by a *Provider*/*Practitioner*.

(3) It must be safe and effective in treating the condition for which it is ordered.

(4) It must be part of a course of treatment which is generally accepted by the American medical community. That community includes all of the branches, professional societies, and governmental agencies therein.

(5) It must be of the proper quantity, frequency, and duration for treatment of the condition for which it is ordered.

(6) It must not be redundant when it is combined with other services and supplies that are used to treat the condition for which it is ordered.

(7) It must not be *Experimental* or *Investigational*.

(8) Its purpose must be to restore health and extend life.

This determination may include the consideration of the findings and assessments of the following entities:

- the Office of Medical Application of Research of the National Institute of Health, the Office of Technology Assessment of the United States Congress, or any similar entities;
- national medical associations, societies, and organizations;
- the Federal Drug Administration; and/or
- the Plan Administrator's own medical and legal counsel and advisors.

Medicare – means Title XVIII of the Social Security Act of 1965, as amended. Part A means *Medicare's* hospital plan and Part B means the supplementary medical plan.

Mental or Nervous Disorder – means manic depression, neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Morbid Obesity – means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or twice the medically recommended weight for a person of the same height, age, and mobility as the *Covered Person*.

Out-Of-Network Provider(s)/Practitioner(s) – means an individual *Provider*/*Practitioner*, an organization of *Provider(s)/Practitioner(s),* and other health care *Providers*/*Practitioners* that do not participate in the Preferred Provider Networks offered under the SHBP. The level of coverage for benefits outside of the network is generally less than the level of coverage for benefits within the network.

Plan Year – August 23, 2013, through August 21, 2014.

Preadmission Tests/Testing – means tests performed in a *Hospital* prior to confinement as an inpatient resident, provided:

(1) such tests are related to the performance of a scheduled surgery or a scheduled admission;

(2) such tests have been ordered by a duly-qualified *Provider*/*Practitioner* after a condition requiring such surgery or treatment has been diagnosed and *Hospital*

admission for such surgery or treatment has been requested by the *Provider*/*Practitioner* and confirmed by the *Hospital*; and

(3) the patient is subsequently admitted to the *Hospital*, or the confinement is canceled or postponed because there is a change in the condition, which precludes the surgery or the treatment.

Provider(s)/Practitioner(s) – means an appropriately-licensed Doctor of Medicine (M.D.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Licensed Anesthesiologist (M.D. or D.O), Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Certified Nurse Midwife (C.N.M.), Certified Registered Nurse Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychologist (Ph. D., Ed. D., Speed., or MA), Registered Nurse (R.N.), Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), Speech Therapist, Occupational Therapist (O.T.), *Provider's/Practitioner's* Assistant, Registered Respiratory Therapist R.R.T.), Nutritionist, Nurse Practitioner (A.P.R.N.), or Naturopath (N.D.).

Reasonable and Customary Charge – means both of the following relating to the determination of benefits for *Out-of-Network Providers*/*Practitioners*.

(1) *Reasonable* – the amount which is determined to be *Reasonable* based on the complexity of treatment of a particular case and the prevailing fee for such treatment in the geographic area where the service is provided (in unusual circumstances or cases with medical complications requiring additional time, skill, and experience in connection with a particular service or procedure, moderate variations from the prevailing fee may be permitted); and

(2) *Customary* – the amount which falls within the range of usual charges for a given service charged by most *Provider(s)/Practitioner(s)* with similar training and experience in a geographic area as determined by the Plan Administrator.

Routine Nursery Care – means routine room and board or nursery charges, *Provider's*/*Practitioner's* or surgeon's charges, and any other related charges (including charges for circumcision) incurred while a newborn child is an inpatient in a *Hospital*, but coverage under this provision will not be provided beyond the date the newborn child is first discharged from the *Hospital*.

SHBP – means the Student Health Benefits Plan provided by the Plan Sponsor. Refer to the Plan Document that is applicable for each *Plan Year* that the SHBP is operated.

Significant Break in Coverage – means a period of sixty-three (63) consecutive days during all of which a *Covered Person* did not have any *Creditable Coverage*, but does not include waiting periods or affiliation periods.

Skilled Nursing/Skilled Nursing Facility – means an institution or part thereof constituted and operated pursuant to law which:

(1) provides, for compensation, room and board and 24-hour *Skilled Nursing* service under the full-time supervision of a *Provider*/*Practitioner* or a Registered Nurse. Full-time supervision means a *Provider*/*Practitioner* or Registered Nurse is regularly on the premises at least 40 hours per week;

(2) maintains a daily medical record for each patient;

(3) has a written agreement of arrangement with a *Provider*/*Practitioner* to provide *Emergency Care* for its patients;

(4) qualifies as an extended care facility under *Medicare*, as amended; and

(5) has a written agreement with one or more *Hospitals* providing for the transfer of patients and medical information between the *Hospital* and the skilled or convalescent nursing facility.

In no event, however, will a convalescent or *Skilled Nursing Facility* be deemed to include an institution which is, other than incidentally, a place for rest, for the aged, for treatment of chemical dependency, for the blind or deaf, for the mentally ill, or for the mentally handicapped.

***Student(s)* –** means persons who are students at UNH who are eligible for coverage under the SHBP as defined in Section IV of this Plan Document, entitled SHBP Eligibility. Student(s) also means persons who are enrolled in the International University Transfer Program (IUTP) provided by Navitas and taking classes at the Durham campus of the Plan Sponsor regardless of degree seeking status or credit hours enrolled at UNH. For IUTP students, the Plan Sponsor requires payment of applicable fees for access to UNH Health Services as a condition of having student eligibility for the SHBP. The cost of coverage and period of coverage for IUTP students may vary depending upon the periods they are scheduled to be on the Durham campus of the Plan Sponsor.

Substance Addiction/Abuse – means a substance-induced disorder, which produces a state of psychological and/or physical dependence.

Total Disability or Totally Disabled – means the status of a *Covered Student* who is unable to attend class or complete other required school work as a result of *Injury* or *Illness*. ,. A covered spouse will be considered *Totally Disabled* if he or she is unable to engage in the typical activities of a person of same age and sex as a result of an *Injury* or *Illness*,. A covered child will be considered *Totally Disabled* if he or she meets the requirements for *Total Disability* as defined in Internal Revenue Code Section 22(e)(B).

Uniformed Service – means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service; and any other category of persons designated by the President in the time of war or emergency.

Urgent Care – means care that is provided when an individual's health is not in serious danger, but that individual needs immediate medical attention for an unforeseen *Illness* or *Injury*. Examples of *Illnesses* or *Injuries* in which *Urgent Care* might be needed are a broken or dislocated toe, a cut that needs stitches but is not actively bleeding, or symptoms of a urinary tract infection.

A. Claims Procedures

How a *Covered Person* files a claim for benefits depends on the type of claim. There are several categories of benefits.

(1) Concurrent Care Claim – A claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.

(2) Pre-Service Care Claim – A claim for a benefit under the SHBP with respect to which the terms of the SHBP require approval (usually referred to as *Precertification*) of the benefit in advance of obtaining medical care.

(3) Post-Service Care Claim – A claim for a benefit under the SHBP that is not a pre-service claim.

(4) *Urgent Care* Claim – An *Urgent Care* claim is a claim for medical care or treatment where a delay in deciding the claim:

(a) could seriously jeopardize the life or health of the *Covered Person* or the ability of the *Covered Person* to regain maximum function; or

(b) would subject the *Covered Person* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim in the opinion of a *Provider*/*Practitioner* with knowledge of the *Covered Person's* medical condition.

A *Covered Person* may file any claim for benefits, including ones for concurrent care, pre-service care, or post-service care, by himself or herself, by his or her authorized representative, or by his or her health care service *Provider*/*Practitioner*. Any of these types of claims must be filed using a written form supplied by the Claims Administrator and must be submitted via the U.S. Postal Service or commercial mail/parcel service (such as, but not limited to, UPS or FedEx), by hand delivery, electronically, or by facsimile.

If a *Covered Person's* claim involves *Urgent Care*, a *Covered Person* may initiate a claim for *Urgent Care* benefits for himself or herself if he or she is able, or his or her authorized representative, or treating *Provider*/*Practitioner* may file the claim for him or her. The claim must be submitted via the U.S. Postal Service or commercial mail/parcel service (such as, but not limited to, UPS or FedEx), by hand delivery, electronically, or by facsimile.

A *Covered Person* may file any claim himself or herself, or he or she may designate another person as his or her authorized representative by notifying the Claims Administrator in writing of his or her designation. In that case, all subsequent notices will be provided to the *Covered Person* through his or her authorized representative and decisions concerning that claim will be provided through his or her authorized representative.

The Claims Administrator provides forms for filing those claims and authorized representative designations under the Plan that must be filed in writing. **A *Covered Person* must submit a claim for benefits within 12 months after the date of service.** The completed form (and all invoices pertaining to services received if applicable) must be sent to the Claims Administrator at the following address:

GWH-Cigna
1000 Great West Drive
Kennett, Missouri 63857-3749

Electronic Payer Identification Number: 62308

In-Network prescription benefit claims are processed by UNH Health Services. *Out-Of-Network* prescription benefit claims should be submitted to GWH-Cigna. For customer service calls, contact Consolidated Health Plans, Inc., at 800-633-7867.

If an *Out-of-Network Provider/Practitioner* submits a claim on a *Covered Person*'s behalf, the *Covered Person* will be responsible for the timeliness of the submission. If the *Covered Person* does not provide this information to the Claims Administrator within **12 months** of the date of service, benefits for that health service will be denied or reduced, at the Plan Administrator's discretion. This time limit does not apply if the *Covered Person* is legally incapacitated. If a *Covered Person's* claim relates to an inpatient stay, the date of service is the date the *Covered Person's* inpatient stay ends. If a *Covered Person* provides written authorization to allow direct payment to *Provider(s)/Practitioner(s)*, all, or a portion of any *Covered Expenses* due to a *Provider/Practitioner*, may be paid directly to the *Provider/Practitioner* instead of being paid to the *Covered Person*. The SHBP will not reimburse third parties who have purchased or been assigned benefits by *Provider(s)/Practitioner(s)*.

The Plan Administrator has final authority to determine the amount of benefits that will be paid on any particular benefit claim. The Plan Administrator has delegated the administration of claims processing under the SHBP to the Claims Administrator. In making benefit determinations, the Plan Administrator has the complete discretion and authority to make factual findings regarding a claim and to interpret the terms of the SHBP as they apply to the claims. In any case, a *Covered Person* will receive only those benefits under the SHBP that the Plan Administrator or an *Independent Review Organization* (*IRO*) determines he or she is entitled to receive. Refer also to subsection B, Inquiry, Grievance, and Appeals Process.

If the *Covered Person's* claim involves *Urgent Care*, the *Covered Person* or his or her authorized representative will be notified of the SHBP's initial decision on the claim, whether adverse or not, as soon as is feasible, but in no event more than 72 hours after receiving the claim. If the claim does not include sufficient information for the Claims Administrator to make an intelligent decision, a *Covered Person* or his or her representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. A *Covered Person* will have at least 48 hours to respond to this request. The Claims Administrator then must inform him or her of its decision within 48 hours of receiving the additional information.

If a *Covered Person's* claim is one involving concurrent care, the Claims Administrator will notify the *Covered Person* of its decision, whether adverse or not, within 24 hours after receiving the claim. The *Covered Person* will be given time to provide any additional information required to reach a decision.

If the *Covered Person's* claim is for a pre-service authorization, the Claims Administrator will notify him or her of its initial determination, whether adverse or not, as soon as possible, but not more than fifteen (15) days from the date it receives the claim. This 15-day period may be extended by the Claims Administrator for an additional fifteen (15) days if the extension is required due to matters beyond the Claims Administrator's control. A *Covered Person* will have at least forty-five (45) days to provide any additional information requested of the *Covered Person* by the Claims Administrator.

If the *Covered Person* has filed a post-service claim for reimbursement of medical care services that already have been rendered, the *Covered Person* will be notified of the Claims Administrator's decision on the *Covered Person's* claim only if it is denied in whole or in part. This notification will be issued no more than thirty (30) days after the Claims Administrator receives the claim. The Claims Administrator may extend this 30-day period once for up to fifteen (15) days if the extension is required due to matters beyond the Claims Administrator's control. A *Covered Person* will have at least forty-five (45) days to provide any additional information requested of the *Covered Person* by the Claims Administrator, if the need for the extension is due to the Claim Administrator's need for additional information from the *Covered Person* or his or her health care *Provider*s.

B. Inquiry, Grievance and Appeals Process

Inquiry/Internal Inquiry Process

If you have not received an *Adverse Determination*, denial of benefits, or have a complaint, you must first submit an *Inquiry* to the Claims Administrator. In other words, you are only seeking to obtain information and or make a first attempt to resolve a concern through an *Internal Inquiry Process*. The Claims Administrator has three (3) business days to answer your *Inquiry* or attempt to resolve your concerns. If you are not satisfied the response of the Claims Administrator, you may proceed with the *Grievance* process described in this Section.

First Level Internal Grievance

If you have received an *Adverse Determination*, denial of benefits, have a complaint or if you are not satisfied with the outcome of an *Inquiry* submitted through the *Internal Inquiry Process*, you or a *Provider*/*Practitioner* acting on your behalf, may file a *Grievance* with the Claims Administrator, within one hundred eighty (180) days, requesting a first level review of the *Adverse Determination*. The request may be by telephone, in person, by mail or by electronic means. Any oral *Grievance* made by you will be reduced to writing by the Claims Administrator and a copy will be forwarded to you within 48 hours or receipt.

Within three (3) working days or receipt of your *Grievance*, the Claims Administrator will provide you with the name, address and telephone number of the person or organization designated to coordinate the first level. The reviewers will take into consideration all comments, documents, and other information regarding the request for services submitted by you. You are entitled to provide additional written comments, documents, records and other materials relating to the request for benefits for the reviewers to consider when conducting their review. You are also entitled to receive from the Claims Administrator, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to you request for benefits as well as any new or additional rationale for denial and a reasonable opportunity for you to respond to such new evidence or rationale.

The Claims Administrator will issue a decision to you within the time frames provided below:

(a) With respect to a *Grievance* requesting a first level review of an *Adverse Determination* involving a prospective review request, the Claims Administrator shall notify and issue a decision within a reasonable period of time that is appropriate given your medical condition, but no later than thirty (30) days after the date of its receipt of the *Grievance* requesting the first level review.

(b) With respect to a *Grievance* requesting a first level review of an Adverse Determination involving a retrospective review request, the Claims Administrator shall notify and issue a decision within a reasonable period of time, but no later than sixty (60) days after the date of its receipt of the *Grievance* requesting the first level review.

(c) With respect to a *Grievance* that does not involve an *Adverse Determination*; the Claims Administrator shall issue a decision within twenty (20) days after the date of its receipt of the *Grievance* requesting a review.

If you appeal, the Claims Administrator will review its decision, as well as any additional comments, documentation, records and other information submitted by you, and provide you with a written determination. If the Claims Administrator continues to deny the payment, coverage, or service requested, or you do not receive a timely decision, you may request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Refer to the Section below in entitled External Review.

Second Level Internal Grievance

It is your option, if you are unhappy with the First Level Internal Grievance decision, to have an additional review. You or your authorized representative may request a Second Level Internal Grievance review within forty-five (45) days from receipt of the decision by following the steps outlined above for the First Level Internal Grievance.

Your request will be reviewed by a panel, appointed by the Plan Administrator, which shall consist of individuals who were not involved in the first level review decision and shall take into consideration all comments, documents, records and other information

regarding the request for benefits submitted by you or your authorized representative. You have the right to appear before this panel at the review meeting which will be held within forty-five (45) working days of the receipt of your request. You will be notified at least fifteen (15) working days prior to the date of the review meeting. A written decision will be issued to you within five (5) working days of completing the review.

Expedited Internal Grievance

You or your authorized representative may make a request, either orally or in writing, for an expedited internal review of an *Urgent Care Adverse Determination* involving an admission, availability of care, continued stay or if you have received *Emergency Medical Services* but have not been discharged from a facility. An expedited review decision will be made and you will be notified of the decision as soon as possible but in no event more than 24 hours after receipt of the request for expedited review.

If the Grievance involves an *Adverse Determination* with respect to a concurrent review urgent care request, the service(s) in question will be continued until you have been notified of the Claims Administrator's determination.

External Review

You may request an External Review once you have exhausted the Internal Grievance process or if you have elected not to pursue the Second Level Internal Grievance process. You shall be considered to have exhausted the internal Grievance process, if you:

(a) have filed a *Grievance* involving an *Adverse Determination*; and

(b) except to the extent that you requested or agreed to a delay, have not received a written decision on the *Grievance* from the Claims Administrator within thirty (30) days following the date you filed the *Grievance* with the Claims Administrator.

Standard External Review

Under the Plan Sponsor's voluntary compliance with the Patient Protection and Affordable Care Act (PPACA), a request to the Commissioner of Insurance for the State of New Hampshire is not necessary.

Within five (5) business days following receipt of the external review request, the Claims Administrator shall complete a preliminary review of the request to determine whether:

(a) you are or were a covered person at the time the health care service was requested or provided;
(b) the health care service that is the subject of the *Adverse Determination* is a covered service under your health benefit plan, but is not covered because it does not meet requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;
(c) you have exhausted the internal *Grievance* process; and
(d) you have provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Claims Administrator shall notify you and the Plan Administrator in writing whether the request is complete and eligible for external review.

If the request is not complete, the Claims Administrator will inform you and the Plan Administrator in writing and include what information or materials are needed to make the request complete. If the request is not eligible for external review, the Claims Administrator will notify you and the Plan Administrator in writing and include in the notice the reasons for its ineligibility. If you are not satisfied with this reply, an *IRO* will be asked to review your *Grievance*.

Upon your receipt of your request for review by an *IRO*, the Claims Administrator shall provide, within five (5) business days, the *IRO* with any documents and information considered in making the *Adverse Determination*. The Claims Administrator's failure to provide the documents and information within the time specified shall not delay the conduct of the external review. If the Claims Administrator fails to provide the documents and information within the time specified, the *IRO* may terminate the external review and make a decision to reverse the *Adverse Determination*. Within one (1) business day after making the decision, the *IRO* shall notify you, Claims Administrator, and the Plan Administrator.

The *IRO* shall review all of the information and documents received and any other information submitted in writing by you. Upon receipt of any information submitted by you, the *IRO* shall, within one (1) business day, forward the information to Claims Administrator. Upon receipt of the information, the Claims Administrator may reconsider its *Adverse Determination* that is the subject of the external review. Reconsideration by the Claims Administrator of its *Adverse Determination* or final *Adverse Determination* shall not delay or terminate the external review. The external review may be terminated only if the Claims Administrator decides, upon completion of its reconsideration, to reverse its *Adverse Determination* or final *Adverse Determination* and provide coverage or payment for the health care service that is the subject of the *Adverse Determination* or final *Adverse Determination*.

Within one (1) business day after making the decision to reverse Our Adverse Determination, the Claims Administrator shall notify you, the *IRO*, and the Plan Administrator in writing of its decision. The *IRO* shall terminate the external review upon receipt of the notice from Claims Administrator.

In addition to the documents and information provided, the *IRO* shall consider the following in reaching a decision:

(a) your medical records;
(b) the attending health care professional's recommendation;
(c) consulting reports from appropriate health care professionals and other documents submitted by the health carrier, you, or your treating provider;

(d) the terms of coverage under your health benefit plan with the Claims Administrator to ensure that the *IRO*'s decision is not contrary to the terms of coverage under the your health benefit plan with the Claims Administrator;
(e) the most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
(f) any applicable clinical review criteria developed and used by Claims Administrator or its designee utilization review organization; and
(g) the opinion of the *IRO*'s clinical reviewer or reviewers after considering paragraphs (a) through (f) to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

Within forty-five (45) days after the date of receipt of the request for an external review, the *IRO* shall provide written notice of its decision to uphold or reverse the *Adverse Determination* or the final *Adverse Determination* to you, the Claims Administrator and the Plan Administrator.

The *IRO* shall include in the notice:

(a) a general description of the reason for the request for external review;
(b) the date the *IRO* was notified of the request for review by the Claims Administrator;
(c) the date the external review was conducted;
(d) the date of its decision;
(e) the principal reason or reasons for its decision, including what applicable, if any, evidence-based standards were a basis for its decision;
(f) the rationale for its decision; and
(g) references to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

Upon receipt of a notice of a decision reversing the *Adverse Determination*, the Claims Administrator shall immediately approve the coverage that was the subject of the *Adverse Determination*.

Expedited External Review

You or your authorized representative may make a request for an expedited external review at the time you receive:

(a) an *Adverse Determination* if:

1) the *Adverse Determination* involves a medical condition for which the time for completion of an expedited internal review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; and

2) you have filed a request for an expedited review of a *Grievance* involving an *Adverse Determination if*:

i. you have a medical condition where the time for completion of a standard external would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or
ii. the final *Adverse Determination* concerns an admission, availability of care, continued stay or health care service for which you received *Emergency Medical Services*, but have not been discharged from a facility.

The Claims Administrator or designee utilization review organization shall provide to the *IRO* the documents and any information considered in making the *Adverse Determination*.

Within 72 hours after the date of receipt of the request, the *IRO* shall make a decision to uphold or reverse the *Adverse Determination*. After making their decision, the *IRO* shall notify you, or if applicable, your authorized representative or Claims Administrator. Immediately upon receipt of the notice of a decision reversing *the Adverse Determination*, the Claims Administrator shall approve the coverage that was the subject of *the Adverse Determination*.