

Amendment #2
Effective July 1, 2008
UNIVERSITY OF ST THOMAS
Plan Year 07-01-2008 to 07-01-2009

The Health Benefit Summary Plan Description is hereby amended as follows:

- 1. The following portion(s) of the INTRODUCTION is hereby deleted from the Summary Plan Description.**

UNIVERSITY OF ST THOMAS is named the Plan Administrator for this group health Plan. The Plan Administrator has retained the services of independent Third Party Administrators, to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are Fiserv Health Administrators, Inc. for medical claims, and Fiserv Health Prescription Benefits Administration (also known as Innoviant) for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.

And replaced with:

UNIVERSITY OF ST THOMAS is named the Plan Administrator for this group health Plan. The Plan Administrator has retained the services of independent Third Party Administrators, to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are Fiserv Health Administrators, Inc., D/B/A UMR, hereinafter "UMR" for medical claims, and Innoviant for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.

- 2. Any reference to FISERV HEALTH ADMINISTRATORS, INC., FISERV HEALTH PLAN ADMINISTRATORS, or FISERV HEALTH is hereby deleted and replaced with UMR throughout the Summary Plan Description.**
- 3. Any reference to FISERV HEALTH PRESCRIPTION BENEFITS ADMINISTRATION is hereby deleted and replaced with INNOVIANT throughout the Summary Plan Description.**
- 4. Any reference to FISERV HEALTH CARE MANAGEMENT is hereby deleted and replaced with AVIDYN HEALTH throughout the Summary Plan Description.**
- 5. Any reference to www.fiservhealthservices.com is hereby deleted and replaced with www.UMR.com throughout the Summary Plan Description.**
- 6. Any reference to certify/certification are hereby deleted and replaced with notify/notification throughout the Summary Plan Description where appropriate.**
- 7. Any reference to Medical Necessity or Medically Necessary are hereby deleted and replaced with Clinical Eligibility for Coverage throughout the Summary Plan Description where appropriate.**

8. The following underlined portion(s) of the **BENEFIT CLASS DESCRIPTION** are hereby changed in the Summary Plan Description.

<u>Class</u>	<u>Class Description</u>	<u>Benefit Plan</u>	<u>Reporting Sub</u>
A01	ALL ACTIVE EMPLOYEES PARTICIPATING IN <u>UNITED HEALTHCARE OPTIONS PPO NETWORK WITH MULTIPLAN OVERLAY 90/70 PLAN</u>	001	0001
A02	ALL ACTIVE EMPLOYEES PARTICIPATING IN <u>UNITED HEALTHCARE OPTIONS PPO NETWORK WITH MULTIPLAN OVERLAY 80/60 PLAN</u>	002	0002
A03	ALL ACTIVE EMPLOYEES PARTICIPATING IN <u>UNITED HEALTHCARE OPTIONS PPO NETWORK WITH MULTIPLAN OVERLAY 70/50 PLAN</u>	003	0003
C01	ALL COBRA PARTICIPANTS PARTICIPATING IN <u>UNITED HEALTHCARE OPTIONS PPO NETWORK WITH MULTIPLAN OVERLAY 90/70 PLAN</u>	001	0001
C02	ALL COBRA PARTICIPANTS PARTICIPATING IN <u>UNITED HEALTHCARE OPTIONS PPO NETWORK WITH MULTIPLAN OVERLAY 80/60 PLAN</u>	002	0002
C03	ALL COBRA PARTICIPANTS PARTICIPATING IN <u>UNITED HEALTHCARE OPTIONS PPO NETWORK WITH MULTIPLAN OVERLAY 70/50 PLAN</u>	003	0003

9. The following underlined portion(s) of the **SCHEDULE OF BENEFITS, BENEFIT PLAN 001** is hereby added to the Summary Plan Description.

SUMMARY OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Maternity Benefits:		
Initial Office Visit:		
• Co-pay Per Visit	\$15	Not Applicable
• Paid By Plan After Deductible	100%	70%
<u>Inpatient Hospital Maternity Coverage:</u>		
• <u>Paid By Plan After Deductible</u>	100% (Deductible Waived)	<u>70%</u>

10. The following underlined portion(s) of the SCHEDULE OF BENEFITS, BENEFIT PLAN 002 is hereby added to the Summary Plan Description.

SUMMARY OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Maternity Benefits:		
Initial Office Visit:		
• Co-pay Per Visit	\$15	Not Applicable
• Paid By Plan After Deductible	100%	60%
<u>Inpatient Hospital Maternity Coverage:</u>		
• <u>Paid By Plan After Deductible</u>	<u>100%</u> (Deductible Waived)	<u>60%</u>

11. The following underlined portion(s) of the SCHEDULE OF BENEFITS, BENEFIT PLAN 003 is hereby added to the Summary Plan Description.

SUMMARY OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Maternity Benefits:		
Initial Office Visit:		
• Co-pay Per Visit	\$15	Not Applicable
• Paid By Plan After Deductible	100%	50%
<u>Inpatient Hospital Maternity Coverage:</u>		
• <u>Paid By Plan After Deductible</u>	<u>100%</u> (Deductible Waived)	<u>50%</u>

12. The following underlined portion(s) of the PROVIDER NETWORK is hereby changed in the Summary Plan Description.

- If Your provider belongs to one of the following Networks, Your claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

United Healthcare Options PPO

13. The following underlined portion(s) of the PROVIDER NETWORK is hereby deleted from the Summary Plan Description.

- If Your provider belongs to one of the following Networks, Your claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits, but the providers have agreed to discount their fees. This means that the Covered Person may pay a little less for a particular claim.

PHCS Healthy Directions

14. The following underlined portion(s) of the COVERED MEDICAL BENEFITS are hereby changed in the Summary Plan Description.

This Plan provides coverage for the following Covered Benefits if services are authorized by a Physician and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions or other Plan provisions shown in this document. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

Durable Medical Equipment subject to all of the following:

- The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan.
- If the equipment is purchased, benefits may be payable for subsequent repairs excluding batteries or replacement only if required:
 - due to the growth or development of a Dependent Child;
 - when necessary because of a change in the Covered Person's physical condition; or

15. The following underlined portion(s) of the HOME HEALTH CARE BENEFITS is hereby changed in the Summary Plan Description.

Home Health Care services are provided for patients who are unable to leave their home, as determined by the Utilization Review Organization. You must be certified in advance before receiving services. Please refer to the Utilization Management section for more details. Covered services can include:

16. The following underlined portion(s) of the TRANSPLANT BENEFITS are hereby changed in the Summary Plan Description.

TRANSPLANT EXCLUSIONS AT DESIGNATED AND NON-DESIGNATED TRANSPLANT FACILITIES

- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell), for conditions that are not considered to meet Clinical Eligibility for Coverage and/or are not appropriate, as determined by the Plan.

17. The following underlined portion(s) of the PRESCRIPTION BENEFITS is hereby changed in the Summary Plan Description.

COVERED BENEFITS

- **Prescription Drugs lost as a direct result of a natural disaster.** You will be given the opportunity to prove that Prescriptions otherwise considered Covered Benefits under this Plan were lost due to a natural disaster. Acceptable proof could include, but not necessarily be limited to, proof of other filed claims of loss (homeowner's, property, etc.).

18. Throughout the PRESCRIPTION BENEFITS section, any reference to Medically Necessary is hereby deleted and replaced with to meet the definition of a Covered Benefit.

19. The following underlined portion(s) of the MENTAL HEALTH BENEFITS is hereby changed in the Summary Plan Description.

COVERED BENEFITS

- Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident; and

20. The following underlined portion(s) of the SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY BENEFITS is hereby changed in the Summary Plan Description.

COVERED BENEFITS

- Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident; and

The following underlined portion(s) of the UTILIZATION MANAGEMENT are hereby changed in the Summary Plan Description

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is:

AVIDYN HEALTH
16633 DALLAS PKWY STE 500
ADDISON TX 75001
1-866-494-4502

21. The following portion(s) of the UTILIZATION MANAGEMENT is hereby deleted from the Summary Plan Description.

DEFINITIONS

Certified or Certification for the purpose of Hospital admission for giving birth means notification to the Utilization Review Organization of the upcoming need for medical treatment and where services will be provided. For all other purposes, Certification means a determination by the Utilization Review Organization on behalf of the Plan, with respect to whether a service, treatment, supply or facility is Medically Necessary for the care and treatment of an Illness or Injury.

And replaced with:

DEFINITIONS

Notified or Notification means a determination by the Utilization Review Organization on behalf of the Plan, with respect to whether a service, treatment, supply or facility is the most appropriate and cost-effective treatment for the care and treatment of an Illness or Injury and meets Clinical Eligibility for Coverage.

22. The following underlined portion(s) of the CLAIMS AND APPEAL PROCEDURES are hereby changed in the Summary Plan Description.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the coverage for the treatment ending or being reduced.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

- Failure to comply with notification requirements before receiving services.

23. The following underlined portion(s) of the GLOSSARY OF TERMS are hereby added to the Summary Plan Description.

Clinical Eligibility for Coverage – Refer to Covered Benefits in the Glossary of Terms section of this SPD.

Covered Benefit or Clinical Eligibility for Coverage means treatment, services, supplies, medicines or facilities necessary and appropriate for the diagnosis, care or treatment of an Illness or Injury and that meet Clinical Eligibility for Coverage as determined by the Plan. Covered Benefits do not include those listed under the Exclusions section but include services, supplies, medicines or facilities that are:

- Generally provided in accordance with accepted medical practice and professionally recognized standards; and
- Provided safely at the appropriate level of care or services; and
- Not provided solely for the convenience of the Covered Person, his or her family, or any provider; and
- Is known to be effective in improving health outcomes. For new interventions, effectiveness is determined by scientific evidence, then by professional standards, and finally by expert opinions; and
- Is cost-effective for the condition, compared to alternative interventions, including no intervention. Cost-effective does not necessarily mean the lowest price.

In determining Covered Benefits, consideration is given to the customary practice of providers in the community or field of specialty. However, the fact that a provider may prescribe, order, recommend or approve a service, supply, medicine or facility does not, of itself, make the service a Covered Benefit.

24. The following definition(s) of the GLOSSARY OF TERMS is hereby deleted from the Summary Plan Description.

Medically Necessary or Medical Necessity

BY THIS AGREEMENT,

The UNIVERSITY OF ST THOMAS Health Benefit Summary Plan Description

Plan Year 07-01-2008 to 07-01-2009

is hereby amended July 1, 2008.

Authorized Signature _____

Print Name _____

Title _____

Date _____

IMPORTANT NOTICE:

By signing this page the Employer agrees to all sections of this amendment as the basis for Plan administration. Except as specifically stated above, nothing in this amendment shall alter or amend the summary plan description.

Lack of a signature page can lead to incomplete coding of the claim payment system and inconsistencies in claims and appeal processing. Furthermore, stop loss policies rely on formally approved amendments or updated summary plan description when determining whether reimbursement is appropriate. Failure to notify the stop loss carrier of plan changes can result in a stop loss gap or lapse in coverage. Notice to the stop loss carrier is required.

When the signature page is received, UMR will send a copy of it to the stop loss carrier, which will constitute required notice.

Please sign and return to UMR via fax at 715.841.7521 as soon as possible. Remember to keep a copy for your records.

Please note UMR will not print amendments or booklets until a signature page is received.

Any modifications made to this amendment will cause it to become null and void and require that a new signature page be signed.