Saint Louis University
Qualified High Deductible Health Plan
Choice Plus *Plan*

With this QHDHP Choice Plus high-deductible health plan coverage, you have the option to open a Health Savings Account (HSA). An HSA is a financial account that you can use to accumulate tax-free funds to pay for qualified health care expenses, as defined by the Internal Revenue Service. The account acts like a regular checking account with a debit card and accrues interest. All money in the account is owned by you and is fully vested as soon as it is deposited. Funds can accumulate over time and the account is portable among employers. If you use the funds for qualified health care expenses, you will pay no taxes. If you use the money for other expenses, you will pay a tax and a penalty fee.

QHDHP Choice Plus plan gives you the freedom to see any Physician or other health care professional from the Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, your plan only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care*.

Some of the Important Benefits of Your Plan:

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral. Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care Coordination^{SM} services are available to help identify and prevent delays in care for those who might need specialized help.

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered. Routine check-ups are covered.

Childhood immunizations are covered.

Mammograms are covered.

Vision and hearing screenings are covered.

QHDHP Choice Plus *Benefits Summary*

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. More complete descriptions of Benefits and the terms under which they are provided are contained in the Summary Plan Description that you will receive upon enrolling in the Plan. If this Benefit Summary conflicts in any way with the Summary Plan Description issued to your employer, the Summary Plan Description shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description. Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law. Network Benefits are payable for Covered Health Services provided by or under the direction of your Network physician. *Prior Notification is required for certain services.	**Combined Medical and Drug Annual Deductible:** For single coverage, the SLU*Care* & SSM Annual Deductible is $1,500 per Covered Person per calendar year. For family coverage, the SLU*Care* & SSM Annual Deductible is $3,000 per calendar year for all Covered Persons in a family. No one in the family is eligible for benefits until the family deductible is satisfied. **Other Participating Provider:** $1,500 per Covered Person per Calendar year. For family coverage, $3,000 per calendar year for all Covered Persons in a family. No one in the family is eligible for benefits until the family deductible is satisfied **Combined Medical and Drug Out-of-Pocket Maximum:** For single coverage, the SLU*Care* & SSM Out-of-Pocket Maximum is $1,500 per Covered Person per calendar year. For family coverage, the SLU*Care* & SSM Out-of-Pocket Maximum is $3,000 per calendar year for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible. **Other Participating Provider:** For single coverage, the Out-of-Pocket Maximum is $3,000 per Covered Person per calendar year. For family coverage, the Out-of-Pocket Maximum is $6,000 per calendar year for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible **Maximum Policy Benefit:** Unlimited.	**Combined Medical and Drug Annual Deductible:** For single coverage, the Annual Deductible is $3,000 per Covered Person per calendar year. For family coverage, the Annual Deductible is $6,000 per calendar year for all Covered Persons in a family. No one in the family is eligible for benefits until the family deductible is satisfied. **Combined Medical and Drug Out-of-Pocket Maximum:** For single coverage, the Out-of-Pocket Maximum is $6,000 per Covered Person per calendar year. For family coverage, the Out-of-Pocket Maximum is $12,000 per calendar year for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible. Any deductible and/or out-of-pocket amounts that are met with a SLU*Care* & SSM or UHC participating provider will cross apply. However, these amounts will not apply to out-of-network benefits. Any deductible and/or out-of-pocket amounts that are met with out-of-network providers will not apply to SLU*Care* & SSM or UHC participating provider **Maximum Policy Benefit:** Unlimited.
Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
1. Ambulance Services - Emergency only	Ground Transportation: 10% After Deductible Air Transportation: 10% After Deductible	Same as Network
2. Dental Services - Accident only	*10% After deductible	*Same as Network Benefit
3. Durable Medical Equipment	10% after deductible	*40% after deductible
4. Emergency Health Services	SLU*Care* & SSM 0% after deductible Other Participating provider: 10% after deductible	10% after deductible *Notification is required if results in an Inpatient Stay.
5. Eye Examinations One routine eye examination per calendar year including refraction.	10% of Eligible Expenses after deductible	40% after deductible Eye Examinations for refractive errors are not covered.
6. Home Health Care Network and Non-Network Benefits are limited to 60 visits for skilled care services per calendar year.	SLU*Care* & SSM 0% after deductible Other Participating Provider: 10% after deductible	*40% after deductible
7. Hospice Care Benefits are unlimited	SLU*Care* & SSM 0% after deductible Other Participating Provider: 10% after deductible	*40% after deductible
8. Hospital - Inpatient Stay	Facility: SLU*Care* & SSM 0% after deductible Physician charges: SLU*Care* & SSM 0% after deductible Other Participating Provider: 10% after deductible	*40% after deductible
9. Injections Received in a Physician's Office	SLU*Care*& SSM 0% per injection after deductible Other Participating Provider 10% after deductible	40% per injection after deductible
10. Maternity Services	Same as 8, 11, 12 and 13	Same as 8, 11, 12 and 13 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
11. Outpatient Surgery, Diagnostic and Therapeutic Services		
Outpatient Surgery	SLU*Care* & SSM 0% after deductible Other Participating provider: 10% after deductible	40% after deductible
Outpatient Diagnostic Services	For preventive diagnostic services: 100% deductible does not apply For preventive mammography testing: 100% deductible does not apply For sickness and injury related diagnostic services: SLU*Care* & SSM 0% after deductible Other Participating provider: 10% after deductible	100% deductible does not apply

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	SLU*Care* & SSM 0% after deductible Other Participating provider: 10% after deductible	40% after deductible
Outpatient Therapeutic Treatments	SLU*Care* & SSM 0% after deductible Other Participating provider: 10% after deductible	40% after deductible
Physician Charges	SLU*Care* & SSM 0% after deductible Other Participating Provider: 10% After Deductible	40% after deductible
12. Physician's Office Services	Preventive medical care: 100% deductible does not apply Sickness & Injury: SLU*Care* & SSM 0% after deductible Other Participating Provider: 10% after deductible	100% deductible does not apply 40% after deductible
13. Professional Fees for Surgical and Medical Services	SLU*Care* 0% after deductible Other Participating Provider: 10% After deductible	40% after deductible
14. Prosthetic Devices	10% after deductible	40% after deductible
15. Reconstructive Procedures	Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14
16. Rehabilitation Services - Outpatient Therapy Network and Non-Network Benefits are limited to 60 visits per calendar year combined for Physical, Occupational, Speech and Pulmonary Therapies. Network and Non-Network services are limited to 36 visits for Cardiac Rehabilitation Therapy..Benefits for Habilitative Services are subject to the limits as stated in the benefit section.	SLU*Care* & SSM 0% after deductible Other Participating Providers 10% after deductible	40% after deductible
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 60 days per calendar year.	10% after deductible Physician charges: SLU*Care* & SSM 0% after deductible Other Participating Provider: 10% after deductible	*40% after deductible
18. Transplantation Services Lodging and meals limited to $200 per day Maximum. Lodging, meals, and transportation Limited to $10,000 per lifetime	*10% after deductible	*40% after deductible
19. Urgent Care Center Services	SLU*Care* & SSM 0% after deductible Other Participating provider: 10% after deductible	40% after deductible
Additional Benefits		
Mental/Nervous Disorders • Hospital • Partial Hospitalization – two partial days equals one Inpatient day • Residential Treatment facility • Physician	Inpatient: SLU*Care* 10% after deductible Other Participating Providers 10% after deductible Outpatient: SLU*Care* 0% after deductible Other Participating Providers 10% after deductible	40% after deductible
Alcoholism and Drug Abuse In network services must receive prior authorization through the Mental Health/Substance Abuse Designee. • Hospital • Partial Hospitalization – two partial days equals one Inpatient day • Residential Treatment facility • Physician	Inpatient: SLU*Care* 10% after deductible Other Participating Providers 10% after deductible Outpatient: SLU*Care* 0% after deductible Other Participating Providers 10% after deductible	40% after deductible
Spinal Treatment Chiropractic visits limited to 26 visits per Calendar Year	10% after deductible	40% after deductible
Wellness Care Routine care includes, but is not limited to: • Physical Examinations • Pap Smear • Mammogram • Prostate Specific Antigen (PSA) • Hearing Screening • Eye Screening (not including refraction) • Immunizations	SLU*Care* Physician: 100% deductible does not apply Other Participating Provider: 100% deductible does not apply	100% deductible does not apply
TMJ • Surgical Treatment • Non-Surgical Treatment Network and Non-Network Benefits are limited to an annual maximum of $5,000 per covered person	Same as 8, 11, 12, and 13	40% after deductible

Exclusions

Except as may be specifically provided in Section 1 of the Summary Plan Description (SPD) or through a Rider to the Plan, the following are not covered:

A. Alternative Treatments

Acupressure; hypnotism; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of the SPD for services to repair a sound natural tooth that has documented accident-related damage, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to ace bandages, gauze and dressings, syringes and diabetic test strips. . Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the SPD.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the SPD.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.) Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the SPD (this exclusion does not apply to mammography testing).

L. Reproduction

Health services and associated expenses for infertility treatments. Surrogate parenting. The reversal of voluntary sterilization. Voluntary termination of pregnancy except where the life of the mother would be in danger if the fetus were carried to term; or where medical complications arise from an abortion. Fetal Reduction surgery. Health Services associated with the use of non-surgical or drug induced Pregnancy termination.

M. Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the SPD. Any solid organ transplant that is performed as a treatment for cancer.Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs.. Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the SPD.

O. Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the SPD.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Plan, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising prior to the date your coverage under the Plan ends.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea.

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring. Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.