



Summary Plan Description

Eden Prairie Independent School #272 Medical Benefit Plan

Open Access Network

Three For Free \$1,500 Deductible Plan

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HEALTHPARTNERS MISSION

*OUR MISSION IS TO IMPROVE HEALTH AND WELL-BEING IN PARTNERSHIP
WITH OUR MEMBERS, PATIENTS AND COMMUNITY.*

ABOUT HEALTHPARTNERS AND YOUR EMPLOYER

HealthPartners Administrators, Inc. (“HPAI”). HPAI (“Plan Manager”) is a third party administrator (TPA). All references to “HealthPartners” throughout this document mean HPAI.

Employer (“Plan Sponsor”). The Employer has established a Medical Benefit Plan (“the Plan” and/or “this Plan”) to provide medical benefits for Covered Employees and their Covered Dependents (“Covered Persons”). The Plan is “self-insured” which means that the Plan Sponsor pays the claims from its own funding as expenses for Covered Services as they are incurred. The Plan is described in the Summary Plan Description (“SPD”). The Plan Sponsor has contracted with HPAI to provide access to its network of health care providers, claims processing, pre-certification and other Plan administration services. However, the Plan Sponsor is solely responsible for payment of your eligible claims.

Powers of the Plan Sponsor. The Plan Sponsor shall have all powers and discretion necessary to administer the Plan, including, without limitation, powers to establish and revise the method of accounting for the Plan; establish rules and prescribe any forms required for administration of the Plan; change the Plan; and terminate the Plan.

The Plan Sponsor, by action of an authorized officer or committee, reserves the right to change the Plan. This includes, but is not limited to, changes to contributions, deductibles, copayments, out-of-pocket limits, benefits payable and any other terms or conditions of the Plan. The Plan Sponsor's decision to change the Plan may be due to changes in applicable laws or for any other reason. The Plan may be changed to transfer the Plan's liabilities to another plan or split the Plan into two or more parts.

The Plan Sponsor shall have the power to delegate specific duties and responsibilities. Any delegation by the Plan Sponsor may allow further delegations by such individuals or entities to whom the delegation has been made. Any delegation may be rescinded by the Plan Sponsor at any time. Each person or entity to whom a duty or responsibility has been delegated shall be responsible for only those duties or responsibilities and shall not be responsible for any act or failure to act of any other individual or entity.

No Guarantee of Employment. The adoption and maintenance of the Plan shall not be deemed to be a contract of employment between the Plan Sponsor and any Covered Employee. Nothing contained herein shall give any Covered Employee the right to be retained in the employ of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge any Covered Employee, any time, nor shall it give the Plan Sponsor the right to require any Covered Employee to remain in its employ or to interfere with the Covered Employee's right to terminate his or her employment at any time.

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INTRODUCTION TO THE SUMMARY PLAN DESCRIPTION

SUMMARY PLAN DESCRIPTION (“SPD”)

This Summary Plan Description effective date is the later of July 1, 2020 and the Covered Person's effective date of coverage under the Plan.

This SPD, along with medical policies (“Medical Coverage Criteria”), is your description of the Employer's Medical Benefit Plan (“the Plan” and/or “this Plan”). The SPD describes the Plan's benefits and limitations. Included in this SPD is a Benefits Chart which states the amount payable for Covered Services. Amendments which are included with this SPD or sent to you at a later date are fully made a part of this SPD. You may access the Medical Coverage Criteria by logging on to your “myHealthPartners” account at healthpartners.com or by calling Member Services.

This SPD should be read completely. Many of its provisions are interrelated; reading just one or two provisions may give you incomplete information regarding your rights and responsibilities under the Plan. Many of the terms used in this SPD have special meanings and are specifically defined in the SPD. Your SPD should be kept in a safe place for your future reference.

The Plan is maintained exclusively for Covered Employees and their Covered Dependents. Each Covered Person's rights under the Plan are legally enforceable. You may not, in any way, assign or transfer your rights or benefits under the Plan. In addition, you may not, in any way, assign or transfer your right to pursue any causes of action arising under the Plan including, but not limited to, causes of action for denial of benefits under the Plan.

MEDICAL ADMINISTRATIVE SERVICES AGREEMENT (“ASA”)

This SPD, together with the ASA between the Plan Sponsor and HPAI, as well as any amendments and any other documents referenced in the ASA, constitute the entire agreement between HPAI and the Plan Sponsor. The ASA is available for inspection at your Employer’s office or at HealthPartners’ home office, at 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

CONFLICT WITH EXISTING LAW

In the event that any provision of this SPD is in conflict with applicable law, that provision only is hereby amended to conform to the minimum requirements of the law.

IDENTIFICATION CARD

An identification card will be issued to you at the time of enrollment. You and your Covered Dependents will be asked to present your identification card, or otherwise show that you are a Covered Person, whenever you seek services. You may not permit anyone else to use your card to obtain care.

HOW TO USE THE NETWORK

This SPD describes your Covered Services and how to obtain them. **The Plan provides Network Benefits and Non-Network Benefits from which you may choose to receive Covered Services.** Coverage may vary according to your network or provider selection. The provisions below contain information you need to know in order to obtain Covered Services.

Designated Physician, Provider, Facility or Vendor. This is a current list of network physicians, providers, facilities or vendors who are authorized to provide certain Covered Services as described in this SPD. Call Member Services or log on to your “myHealthPartners” account at healthpartners.com for a current list.

Network Provider. This is any one of the participating licensed physicians, dentists, mental and chemical health or other health care providers, facilities and pharmacies, who have entered into an agreement to provide health care services to Covered Persons.

To see what physicians and other health care providers are in your network, log on to your “myHealthPartners” account at healthpartners.com. If you need assistance locating a physician or other health care provider in your network, please contact Member Services.

Non-Network Providers. These are licensed physicians, dentists, mental and chemical health or other health care providers, facilities and pharmacies not participating as Network Providers.

ABOUT THE NETWORK

To obtain Network Benefits for Covered Services, you must select and receive services from Network Providers.

Network. This is the network of participating Network Providers.

Network Clinics. These are participating clinics providing ambulatory medical services.

Continuity of Care. In the event you must change your current primary care physician, specialty care physician or general hospital provider because that provider leaves the network or because your Employer changed health plan offerings, you may have the right to continue receiving services from your current provider for a period of time. Some services provided by Non-Network Providers may be considered a covered Network Benefit for up to 120 days under this Plan if you qualify for continuity of care benefits.

The following conditions qualify for this benefit:

- an acute condition;
- a life-threatening mental or physical illness;
- pregnancy beyond the first trimester of pregnancy;
- a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or
- a disabling or chronic condition that is in an acute phase.

You may also request continuity of care benefits for culturally appropriate services or when we do not have a provider who can communicate with you directly or through an interpreter.

Terminally ill patients are also eligible for continuity of care benefits. Continuity of care may continue for the rest of the Covered Person’s life if a physician, advanced practice registered nurse, or physician assistant certifies that the Covered Person has an expected lifetime of 180 days or less.

Call Member Services for further information regarding continuity of care benefits.

Your physician may be required to obtain prior authorization for certain services. Your physician will coordinate the authorization process for any services which must first be authorized. You may call the Member Services Department or log on to your “myHealthPartners” account at healthpartners.com for a list of which services require your physician to obtain prior authorization.

HealthPartners medical or dental directors, or their designees, will determine medical necessity and appropriateness of certain treatments based on established medical policies, which are subject to periodic review and modification.

You must use a designated convenience care clinic to obtain the convenience care benefit. You may call the Member Services Department or log on to your “myHealthPartners” account at healthpartners.com for a list.

Durable medical equipment and supplies must be obtained from or repaired by approved vendors.

Non-emergent, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) must be provided at a designated facility.

All services for the purpose of weight loss must be provided by a designated physician.

Multidisciplinary pain management must be provided at designated facilities.

For specialty drugs that are self-administered, you must obtain the specialty drugs from a designated vendor to be covered as Network Benefits.

Call Member Services for more information on authorization requirements or approved vendors.

Second Opinions for Network Services. If you question a decision or recommendation about medical care, the Plan covers a second opinion from an appropriate Network Provider.

Prescription Drugs and Medical Equipment. Enrolling in the Plan does not guarantee that any particular prescription drug will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment was available previously.

STEP THERAPY OVERRIDE PROCESS

If you are required to follow a step therapy protocol to get coverage of a specific drug, you may request to override this process if certain conditions apply. Information is available on step therapy protocols and how to request a step therapy override by calling Member Services or logging on to your “myHealthPartners” account at healthpartners.com.

If a step therapy override request is denied, you or your prescribing health care provider, if designated by you, may appeal by using the complaint procedure under the “COMPLAINTS” section of this SPD.

You or your prescribing health care provider will receive a response within five days of receipt of a complete request for a step therapy override or an appeal. In cases where exigent circumstances exist, you or your prescribing health care provider, will receive a response within 72 hours of receipt of a complete request.

If you or your prescribing health care provider do not receive a response within this timeline, the override request or appeal is granted and binding on the Plan.

CARECHECK®

It is your responsibility to notify CareCheck® of all services requiring review, as shown below. Failure to follow CareCheck® procedures may result in a reduction of the maximum coverage available to you under the Plan. You can designate another person to contact CareCheck® for you.

CARECHECK® Services. CareCheck® is HealthPartners utilization review program for non-network services. CareCheck® must pre-certify all inpatient confinement and same day surgery; new, experimental or reconstructive outpatient technologies or procedures; durable medical equipment or prosthetics costing over \$3,000; home health services after your visits exceed 30 and skilled nursing facility stays.

Procedure to Follow to Receive Maximum Benefits

- **For medical emergencies.** A certification request is to be made by phone to CareCheck® as soon as reasonably possible after the emergency. You will not be denied full coverage because of your failure to gain certification prior to your emergency.
- **For medical non-emergencies.** A phone call must be made to CareCheck® when services requiring pre-certification are scheduled, but not less than 48 hours prior to that date. CareCheck® advises the physician and the hospital, or skilled nursing facility, by phone, if the request is approved. This will be confirmed by written notice within 10 days of the decision.

Failure to Comply with CareCheck® Requirements. If you fail to make a request for pre-certification of services in the time noted above, but your services requiring pre-certification are subsequently approved as medically necessary, we will reduce the eligible charges by 20%.

CareCheck® Certification Does Not Guarantee Benefits. CareCheck® does not guarantee either payment or the amount of payment. Eligibility and payment are subject to all of the terms of the SPD. CareCheck® only certifies medical necessity.

Information Needed When You Call CareCheck®.

When you or another person contacts CareCheck®, this information is needed:

- the Covered Person's name, address, phone number, birth date and ID number;
- the attending physician's name, address, and phone number;
- the facility's name, address, and phone number;
- the reason for the services requiring review, as shown above.

Pre-certification Process.

When a pre-certification for a non-urgent service is requested from HealthPartners, an initial determination must be made within 15 calendar days. This time period may be extended for an additional 15 calendar days, provided that the Plan Manager determines that such extension is necessary due to matters beyond the control of the Plan. If such extension is necessary, you will be notified prior to the expiration of the initial 15-day period.

When a pre-certification for an urgent service is requested from HealthPartners, an initial determination must be made within 72 hours, so long as all information reasonably needed to make a decision has been provided. In the event that the claimant has not provided all information necessary to make a decision, the claimant will be notified of such failure within 24 hours. The claimant will then be given 48 hours to provide the requested information. The claimant will be notified of the benefit determination within 48 hours after the earlier of HealthPartners receipt of the complete information or the end of the time granted to the claimant to provide the specified additional information.

How to contact CareCheck®: You may call **952-883-6400** in the Minneapolis/St. Paul metro area, or **800-316-9807** (toll-free) outside the metro area, from 8:00 a.m. to 5:00 p.m. (Central Time) weekdays. You can leave a recorded message at other times. You may also write CareCheck® at Quality Utilization Management Department, 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

ELIGIBILITY

The following persons will be eligible for coverage under this Plan:

1. All employees, as determined by the Plan Sponsor, working 25 hours per week (actively at work). Employees must enroll themselves and any eligible dependents within 31 days of the date they first become eligible. The employee must enroll a newly acquired dependent (such as a new spouse) within 31 days of when the new dependent is first acquired. There may be additional situations when the employee is eligible to enroll after the first 31 days of eligibility. If there are any questions, contact the Plan Sponsor and see "Late Enrollment" below.
2. Teachers working a minimum of 0.6 FTE.
3. Bus drivers working both AM and PM shifts totaling at least 17.5 hours per week.
4. All early retirees as defined by the Plan Sponsor.

EFFECTIVE DATE OF COVERAGE

The employee's and any dependent's effective date is the date of hire.

An employee must be actively at work on the initial effective date of coverage or coverage for the employee and dependents will be delayed until the date the employee returns to work. The effective date of coverage shall not be delayed if the employee is not actively at work due to the employee's health status, medical condition, or disability.

For purposes of this provision, “actively at work” is the time period in which an employee is customarily performing all the regular duties of his or her occupation at the usual place of employment or business, or at some location to which that employment requires travel. An employee is considered actively at work for the time period absent from work solely by reason of vacation or holiday, if the employee was actively at work on the last preceding regular workday.

LATE ENROLLMENT

If you are a late enrollee, you may only enroll yourself and any eligible dependents during the Employer’s annual open enrollment or if you or your dependents have met the criteria under “Special Enrollment Period” below.

SPECIAL ENROLLMENT PERIOD

An employee who is eligible, but not enrolled for coverage under the Plan, or a dependent of such employee if the dependent is eligible but not enrolled for coverage under the Plan, may enroll for coverage under the terms of the Plan if all of the following conditions are met:

1. the employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;
2. the employee stated in writing at the time of initial eligibility that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the Plan Sponsor required such a statement at such time and provided the employee with notice of such requirement and the consequences of such requirement at such time;
3. the employee's or dependent's coverage described in 1. above was:
 - a. under a COBRA continuation provision and the coverage under such provision was exhausted; or
 - b. not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including: as a result of legal separation; divorce; death; termination of employment; cessation of dependent status; reduction in the number of hours of employment; a situation in which the individual incurs a claim that would meet or exceed a lifetime limit on all benefits; a situation in which coverage is no longer offered to a class of similarly situated individuals that includes the individual; a situation in which an individual loses coverage through a health maintenance organization or other arrangement because that individual no longer resides, lives or works in the health maintenance organization’s service area or a situation in which the individual’s benefit option is terminated) or employer contributions toward such coverage were terminated; and
4. the employee requested such enrollment not later than 31 days after the date of exhaustion of coverage described in 3.a. above, or one of the events listed in 3.b. above.

Dependent beneficiaries may enroll if: (a) a group health plan makes coverage available with respect to a dependent of an employee; (b) the employee is covered under the Plan (or has met any waiting period applicable to becoming a participant under the Plan and is eligible to be enrolled under the Plan but for a failure to enroll during a previous enrollment period); and (c) a person becomes a dependent of the employee through marriage, birth, or adoption or placement for adoption. The Plan shall provide for a dependent Special Enrollment Period during which the person (or, if not otherwise enrolled, the employee) may be enrolled under the Plan as a dependent of the employee and in the case of the birth or adoption of a child, the spouse of the employee may be enrolled as a dependent of the employee if such spouse is otherwise eligible for coverage. A dependent Special Enrollment Period shall be a period of not less than 31 days and shall begin on the later of:

- the date dependent coverage is made available; or
- the date of the marriage, birth, or adoption or placement for adoption described in (c) in the paragraph above.

If an individual seeks to enroll a dependent during the first 31 days of such a dependent Special Enrollment Period, the coverage of the dependent shall become effective:

- in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
- in the case of a dependent's birth, as of the date of such birth; or
- in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

SPECIAL RULES RELATING TO MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM ("CHIP")

In general – an employee who is eligible but not enrolled for coverage under the terms of the Plan (or a dependent of such an employee if the dependent is eligible but not enrolled for coverage under such terms) may enroll for coverage under the terms of the Plan if either of the following conditions is met:

- Termination of Medicaid or CHIP Coverage – the employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a state child health plan under title XXI of such Act and coverage of the employee or dependent under such plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the Plan not later than 60 days after the date; or
- Eligibility for Employment Assistance under Medicaid or CHIP – the employee or dependent becomes eligible for assistance, with respect to coverage under the Plan, under such Medicaid plan or state child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the Plan not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

ENROLLMENT OF NEWBORN OR NEWLY ADOPTED CHILDREN

Newborn infants (including a newborn grandchild of a covered grandparent) and a newly adopted child may be covered regardless of when notice is received by the Plan. However, the Plan must receive required payments, if any, from the date of eligibility for a newborn infant (including a newborn grandchild of a covered grandparent) and a newly adopted child before benefits will be paid. You must notify the Plan immediately of any change in eligibility of an enrolled dependent.

CHANGES IN BENEFITS

Any change in benefits is subject to the Plan Sponsor's approval. If a change in benefits is requested by the Plan Sponsor or the Plan Manager, it is effective on the date they agree to. Any change in benefits required by law becomes effective according to law.

TERMINATION

A Covered Person's coverage under the Plan terminates when any of the following events occur:

1. The contribution for coverage under the Plan is not made by the due date.
2. When a Covered Employee ceases to be eligible under the terms of this Plan, coverage for the employee and all Covered Dependents terminates on the last day of the month in which the employee's eligibility ceases, unless group continuation is elected as described in the "CONTINUATION OF GROUP COVERAGE" section of this SPD.
3. When a Covered Dependent no longer meets this Plan's definition of eligible dependent, coverage for that dependent terminates on the last day of the month in which the dependent's eligibility ceases, unless group continuation is elected as described in the "CONTINUATION OF GROUP COVERAGE" section of this SPD.
4. When the maximum period under the group continuation coverage described in the "CONTINUATION OF GROUP COVERAGE" section of this SPD expires for a Covered Person.

5. When the Plan terminates.
6. In the event of misrepresentation or omission of a material fact by the Covered Person regarding eligibility, enrollment, other coverage, claims or other expenses, the Plan Sponsor has the right to rescind this SPD or disenroll the Covered Person.

To the extent that a termination would be considered a rescission under federal law under terms 2. and 3., the Plan Sponsor is required to give the Covered Person 30 days advance notice of termination.

ACCESS TO RECORDS AND CONFIDENTIALITY

The Plan Sponsor complies with applicable state and federal laws governing the confidentiality and use of protected health information and medical records. As part of this Summary Plan Description, the Plan Sponsor is authorized to have access to and use protected health information held by any health care provider who delivers health care services to you under this Summary Plan Description. The Plan Sponsor is also allowed to use your protected health information when necessary, for: certain health care operations including, but not limited to, claims processing, including claims made for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, case management; care coordination and utilization management, disease management, underwriting, premium rating, claims experience reporting, the evaluation of potential or actual claims against the Plan Sponsor, auditing and legal services, and other access and use without further authorization if permitted or required by another law.

In the event that protected health information is disclosed to the Plan Sponsor, the Plan Sponsor may only use or disclose such information as permitted by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and regulations promulgated thereunder and as amended including, certain Plan administrative functions such as: claims review, subrogation, quality assurance, auditing, monitoring and management of carve out plans. Information may only be disclosed to the Plan Sponsor upon receipt, by the Plan, of a certification from the Plan Sponsor to the amendment of the Plan documents and that your Plan Sponsor agrees to:

- Not use or further disclose information except as listed above or as required or permitted by law;
- Ensure that any agents or subcontractors agree to the same restrictions and conditions that apply to your Employer or Plan Sponsor and that such agents and subcontractors agree to implement reasonable and appropriate security measures to protect electronic protected health information;
- Not use or disclose any information for employment – related actions or decisions;
- Not use or disclose any information in connection with any other employee benefit plan of your Employer or Plan Sponsor;
- Report to the Plan any security incident it becomes aware of and any use or disclosure of the information that is inconsistent with the uses or disclosures described above;
- Make information available to fulfill your right to access your protected health information;
- Make the information available for amendment or to incorporate applicable amendments;
- Make the information available in order to provide an accounting of disclosures;
- Make its internal practices, books and records relating to the use and disclosure of information received from the Plan available to the Department of Health and Human Services to determine compliance with HIPAA;
- Return or destroy all protected health information received from the Plan, if feasible, when use or disclosure is no longer required. If return or destruction is not possible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- Ensure only certain classes of employees designated by your Employer are permitted access to your protected health information for Plan administration functions;
- Implement an effective mechanism for handling noncompliance by the employees designated access to your protected health information;
- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic protected health information that is created, received, maintained or transmitted on behalf of the group health plan;
- Ensure adequate separation between the Plan and your Plan Sponsor is supported by reasonable and appropriate security measures.

BENEFITS CHART

The amount that the Plan pays for Covered Services is listed below. The Covered Person is responsible for the specified dollar amount and/or percentage of charges that the Plan does not pay.

To be covered under this Plan, the medical or dental services or items described below must be medically necessary or dentally necessary.

Coverage is subject to the exclusions, limitations, and other conditions of this SPD.

Covered Services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. Covered prescription drugs are based on requirements established by the HealthPartners Pharmacy and Therapeutics Committee, and are subject to periodic review and modification. The Medical Coverage Criteria and formulary requirements are available by logging on to your “myHealthPartners” account at healthpartners.com or by calling Member Services.

Coverage may vary according to your network or provider selection.

When you use Non-Network Providers, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses. A Non-Network Provider does not have an agreement with HealthPartners to provide services at the discounted fee. In addition, most Non-Network Benefits are restricted to the usual and customary amount as described under the definition of “Charge”. If the Non-Network Provider’s billed charges are over the usual and customary amount, you pay the difference, in addition to any required deductible, copayment and/or coinsurance, and these charges do not apply to the out-of-pocket limit. The only exceptions to this requirement are described in the Benefits Chart under the “Emergency and Urgently Needed Care Services” section. These services are covered at the Network Benefit level regardless of who provides the service.

- Calendar Year:** This is the 12-month period beginning 12:01 A.M. Central Time, on January 1, and ending at midnight Central Time of the next following December 31.
- Charge:** For Covered Services delivered by participating Network Providers, this is the provider's discounted charge for a given medical/surgical service, procedure or item.
- For Covered Services delivered by Non-Network Providers, a contracted rate may apply if such arrangement is available to the Plan Manager.
- For the usual and customary charge for Covered Services delivered by Non-Network Providers, the Plan’s payment is calculated using the following options in the following order depending on availability: (1) 140% of the Medicare fee schedule; (2) a comparable schedule if the service is not available on the Medicare fee schedule; or (3) a commercially reasonable rate for such service.
- The usual and customary charge is the maximum amount allowed that the Plan considers in the calculation of the payment of charges incurred for certain Covered Services. You must pay for any charges above the usual and customary charge, and they do not apply to the out-of-pocket limit.
- A charge is incurred for covered ambulatory medical, inpatient professional fees, and surgical services on the date the service or item is provided. A charge is incurred for covered inpatient facility fees on the date of admission to a hospital. To be covered, a charge must be incurred on or after the Covered Person's effective date and on or before the termination date.

Copayment/Coinsurance: The specified dollar amount, or percentage, of charges incurred for Covered Services, which the Plan does not pay, but which a Covered Person must pay, each time a Covered Person receives certain medical services, procedures or items. The Plan's payment for those Covered Services or items begins after the copayment or coinsurance is satisfied. Covered Services or items requiring a copayment or coinsurance are specified in this SPD.

For services provided by a Network Provider:

The amount which is listed as a percentage of charges or coinsurance is based on the Network Providers' discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule rate for case rate or withhold arrangements. However, if a Network Providers' discounted charge for a service or item is less than the flat dollar copayment, you will pay the Network Providers' discounted charge. A copayment or coinsurance is due at the time a service is provided, or when billed by the provider.

For services provided by a Non-Network Provider:

Any copayment or coinsurance is applied to the lesser of the providers' charge or the usual and customary charge for a service.

The copayment or coinsurance applicable for a scheduled visit with a Network Provider will be collected for each visit, late cancellation and failed appointment.

Deductible: The specified dollar amount of charges incurred for Covered Services, which the Plan does not pay, but a Covered Person or a covered family has to pay first in a calendar year. The Plan's payment for those services or items begins after the deductible is satisfied. If you have a family deductible, each individual family member may only contribute up to the individual deductible amount toward the family deductible. An individual's copayments and coinsurance do not apply toward the family deductible. For Network Providers, the amount of charges that apply to the deductible are based on the Network Providers' discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule for case rate or withhold arrangements. For Non-Network Providers, the amount of charges that apply to the deductible are the lesser of the providers' charges or the usual and customary charge for a service.

Unless prohibited by applicable law, any amounts paid or reimbursed by a third party, including, but not limited to, point of service rebates; manufacturer coupons; manufacturer debit cards or other forms of direct reimbursement to a Covered Person for a product or service, may not apply toward your deductible.

Out-of-Pocket Expenses: You pay the specified copayments/coinsurance and deductibles applicable for particular services, subject to the out-of-pocket limit described below. These amounts are in addition to employee contributions.

Out-of-Pocket Limit: You pay the copayments/coinsurance and deductibles for Covered Services, to the individual or family out-of-pocket limit. Thereafter, 100% of charges incurred are covered under the Plan for all other Covered Services for the rest of the calendar year. You pay amounts greater than the out-of-pocket limit if you exceed any visit or day limits.

Non-Network Benefits for transplant surgery do not apply to the out-of-pocket limit and will not be paid at 100% once the out-of-pocket limit has been met.

Non-Network Benefits above the usual and customary charge (see definition of charge) do not apply to the out-of-pocket limit.

The reduction in benefits for failure to comply with CareCheck® requirements will not apply toward the out-of-pocket limit.

Unless prohibited by applicable law, any amounts paid or reimbursed by a third party, including, but not limited to, point of service rebates; manufacturer coupons; manufacturer debit cards or other forms of direct reimbursement to a Covered Person for a product or service, may not apply as an out-of-pocket expense.

You are responsible to keep track of the out-of-pocket expenses. Contact HealthPartners Member Services department for assistance in determining the amount paid by the Covered Person for specific eligible services received. Claims for reimbursement under the out-of-pocket limit provisions are subject to the same time limits and provisions described under the “CLAIMS PROCEDURES” section of the SPD.

DEDUCTIBLES AND OUT-OF-POCKET LIMITS

Calendar Year Deductible

Individual Calendar Year Deductible

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
\$1,500	\$2,500

Family Calendar Year Deductible

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
\$3,000	\$5,000

The deductibles under the Network Benefits and the Non-Network Benefits are combined.

Calendar Year Out-of-Pocket Limit

Individual Calendar Year Out-of-Pocket Limit

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
\$3,000	\$5,000

Family Calendar Year Out-of-Pocket Limit

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
\$6,000	\$10,000

The out-of-pocket limits under the Network Benefits and the Non-Network Benefits are combined.

Non-Network Benefits for transplant surgery do not apply to the out-of-pocket limit and will not be paid at 100% once the out-of-pocket limit has been met.

Non-Network Benefits above the usual and customary charge (see definition of charge) do not apply to the out-of-pocket limit.

Any reduction in benefits for failure to comply with CareCheck[®] requirements will not apply toward the out-of-pocket limit.

BENEFIT DESCRIPTIONS

Notice: You may be required to get pre-certification before using certain Non-Network services. See “CareCheck®” in this SPD for specific information about pre-certification.

ACUPUNCTURE

Covered Services:

The Plan covers acupuncture services when medically necessary.

Covered Services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. The Medical Coverage Criteria are available by logging on to your “myHealthPartners” account at healthpartners.com or by calling Member Services.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

AMBULANCE AND MEDICAL TRANSPORTATION

Covered Services:

The Plan covers certain ambulance and medical transportation for medical emergencies and medically necessary, non-emergency medical transportation if it meets the Medical Coverage Criteria.

Covered Services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. The Medical Coverage Criteria and applicable prior authorization requirements are available by logging on to your “myHealthPartners” account at healthpartners.com or by calling Member Services.

Ambulance and Medical Transportation (other than Non-Emergency Fixed Wing Air Ambulance Transportation)

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	See Network Benefits.

Non-Emergency Fixed Wing Air Ambulance Transportation

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

AUTISM TREATMENT

Covered Services:

The Plan covers the diagnosis, evaluations, multidisciplinary assessment and medically necessary care of children under age 18 with autism spectrum disorders, including, but not limited to, the following:

- early intensive behavioral and developmental therapy based in behavioral and developmental science, including, but not limited to, all types of applied behavior analysis, intensive early intervention behavior therapy and intensive behavior intervention;
- neurodevelopmental and behavioral health treatments and management;
- speech therapy;
- occupational therapy;
- physical therapy; and
- medications.

The diagnosis, evaluation and assessment includes an assessment of the child’s developmental skills, functional behavior, needs and capacities. Treatment must be in accordance with an individualized treatment plan prescribed by the Covered Person’s treating physician or mental health professional.

The Plan can request an updated treatment plan no more frequently than once every six months, unless we or your attending physician agree that a more frequent review is necessary due to emerging circumstances.

An independent progress evaluation conducted by a mental health professional with expertise and training in autism spectrum disorder and child development must be completed to determine if progress toward function and generalizable gains, as determined in the treatment plan, is being made.

Physical therapy, occupational therapy and speech therapy are covered under the “Physical Therapy, Occupational Therapy and Speech Therapy” section of this Benefits Chart. Coverage for medications are covered under the “Prescription Drug Services” section of this Benefits Chart.

Covered Services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. The Medical Coverage Criteria are available by logging on to your “myHealthPartners” account at healthpartners.com or by calling Member Services.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

BEHAVIORAL HEALTH SERVICES

Covered Services:

Covered Services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. The Medical Coverage Criteria are available by logging on to your “myHealthPartners” account at healthpartners.com or by calling Member Services.

Mental Health Services

The Plan covers services for mental health diagnoses as described in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM 5) (most recent edition) that lead to significant disruption of function in the Covered Person's life.

The Plan also provides coverage for mental health treatment ordered by a Minnesota court under a valid court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. The Plan Manager must be given a copy of the court order and the behavioral care evaluation, the service must be a covered benefit under this Plan and the service must be provided by a Network Provider or other provider as required by law. The Plan will cover the evaluation upon which the court order was based if it was provided by a Network Provider or other provider as required by law. The Plan also provides coverage for the initial mental health evaluation of a child, regardless of whether that evaluation leads to a court order for treatment, if the evaluation is ordered by a Minnesota juvenile court.

Outpatient Services, including Intensive Outpatient Services and Day Treatment. The Plan covers medically necessary outpatient professional mental health services for evaluation, crisis intervention, and treatment of mental health disorders.

A comprehensive diagnostic assessment will be made of each patient as the basis for a determination by a mental health professional, concerning the appropriate treatment and the extent of services required.

Outpatient services covered by the Plan for a diagnosed mental health condition include the following:

- Individual, group, family, and multi-family therapy;
- Medication management provided by a physician, certified nurse practitioner, or physician’s assistant;
- Psychological testing services for the purposes of determining the differential diagnoses and treatment planning for patients currently receiving behavioral health services;
- Day treatment and intensive outpatient services in a licensed program;
- Partial hospitalization services in a licensed hospital or community mental health center;
- Psychotherapy and nursing services provided in the home if authorized by HealthPartners; and
- Treatment for gender dysphoria that meets the Medical Coverage Criteria.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
<p>75% of the charges incurred, after you pay the deductible.</p> <p>The first three mental and chemical health visits, urgent care visits, office visits, convenience clinic visits, telephone visits and e-visits (other than virtuwell) combined in a calendar year are covered at 100%, not subject to the deductible. Physician’s services are included; however, charges for day treatment services, group visits, office procedures, laboratory, radiology and other ancillary services are not included and will be subject to your deductible and coinsurance.</p>	<p>55% of the charges incurred, after you pay the deductible.</p>

Group Therapy

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
<p>75% of the charges incurred, after you pay the deductible.</p>	<p>55% of the charges incurred, after you pay the deductible.</p>

Inpatient Services, including Psychiatric Treatment for Emotionally Disabled Children. The Plan covers medically necessary inpatient services in a hospital and professional services for treatment of mental health disorders. Medical stabilization is covered under inpatient hospital services in the “Hospital and Skilled Nursing Facility Services” section.

The Plan covers residential care for the treatment of eating disorders in a licensed facility, as an alternative to inpatient care, when it is medically necessary and your physician obtains authorization from HealthPartners.

The Plan also covers medically necessary psychiatric residential treatment for emotionally disabled children as diagnosed by a physician. This care must be authorized by HealthPartners and provided by a hospital or residential treatment center licensed by the local state or Department of Health and Human Services. For purposes of this provision “emotionally disabled child” shall have the meaning set forth by the commissioner of human services in the rules relating to residential treatment facilities, and the child must be under 18 years of age and an eligible dependent under the terms of this Plan. Services not covered under this benefit include shelter services, correctional services, detention services, transitional services, group homes, foster care services and wilderness programs.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Chemical Health Services

The Plan covers medically necessary services for assessments by a licensed alcohol and drug counselor and treatment of substance-related disorders as defined in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM 5) (most recent edition).

Outpatient Services, including Intensive Outpatient Services and Day Treatment. The Plan covers medically necessary outpatient professional services for diagnosis and treatment of chemical dependency. Chemical dependency treatment services must be provided by a program licensed by the local Department of Health and Human Services.

Outpatient services covered by the Plan for a diagnosed chemical dependency condition include the following:

- Individual, group, family, and multi-family therapy provided in an office setting;
- Opiate replacement therapy including methadone and buprenorphine treatment; and
- Day treatment and intensive outpatient services in a licensed program.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible. The first three mental and chemical health visits, urgent care visits, office visits, convenience clinic visits, telephone visits and e-visits (other than virtuwell) combined in a calendar year are covered at 100%, not subject to the deductible. Physician’s services are included; however, charges for day treatment services, group visits, office procedures, laboratory, radiology and other ancillary services are not included and will be subject to your deductible and coinsurance.	55% of the charges incurred, after you pay the deductible.

Inpatient Services. The Plan covers medically necessary inpatient services in a hospital or primary residential treatment in a licensed chemical health treatment center. Primary residential treatment is an intensive residential treatment program of limited duration, typically 30 days or less.

The Plan covers services provided in a hospital that is licensed by the local state and accredited by Medicare.

Detoxification Services. The Plan covers detoxification services in a hospital or community detoxification facility if it is licensed by the local Department of Health and Human Services.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

CHIROPRACTIC SERVICES

Covered Services:

The Plan covers chiropractic services for rehabilitative care, rendered to diagnose and treat acute neuromusculoskeletal conditions.

Massage therapy which is performed in conjunction with other treatment/modalities by a chiropractor and is part of a prescribed treatment plan and is not billed separately is covered.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible. Limited to 20 visits per calendar year.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

CLINICAL TRIALS

Covered Services:

The Plan covers certain routine services if you participate in a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition as defined in the Affordable Care Act. The Plan covers routine patient costs for services that would be eligible under this Plan if the service was provided outside a clinical trial.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
Coverage level is same as corresponding Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Non-Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

DENTAL SERVICES

Covered Services:

Accidental Dental Services. The Plan covers dentally necessary services to treat and restore damage done to sound, natural, unrestored teeth as a result of an accidental injury. Coverage is for damage caused by external trauma to face and mouth only, not for cracked or broken teeth which result from biting or chewing. The Plan covers restorations, root canals, crowns and replacement of teeth lost that are directly related to the accident in which the Covered Person was involved. The Plan covers initial exams, x-rays, and palliative treatment including extractions, and other oral surgical procedures directly related to the accident. Subsequent treatment must be initiated within six months of the date of the injury and must be related to the accident. The Plan does not cover restoration and replacement of teeth that are not “sound and natural” at the time of the accident.

Full mouth rehabilitation to correct occlusion (bite) and malocclusion (misaligned teeth not due to the accident) are not covered.

When an implant-supported dental prosthetic treatment is pursued, the accidental dental benefit will be applied to the prosthetic procedure. Benefits are limited to the amount that would be paid toward the placement of a removable dental prosthetic appliance that could be used in the absence of implant treatment.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

For all accidental dental services, treatment and/or restoration must be initiated within six months of the date of the injury. Coverage is limited to the initial course of treatment and/or initial restoration. Services must be provided within 24 months of the date of injury to be covered.

Medical Referral Dental Services

Medically Necessary Outpatient Dental Services. The Plan covers certain medically necessary outpatient dental services. Coverage is limited to dental services required for treatment of an underlying medical condition, e.g., removal of teeth to complete radiation treatment for cancer of the jaw, cysts and lesions.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Medically Necessary Hospitalization and Anesthesia for Dental Care. The Plan covers certain medically necessary hospitalization and anesthesia for dental care. This is limited to charges incurred by a Covered Person who: (1) is a child under age 5; (2) is severely disabled; (3) has a medical condition, and requires hospitalization or general anesthesia for dental care treatment; (4) is a child between ages 5 and 12 and care in dental offices has been attempted unsuccessfully and usual methods of behavior modification have not been successful; or (5) when extensive amounts of restorative care, exceeding four appointments, are required. Coverage is limited to facility and anesthesia charges. Anesthesia is covered in a hospital or a dental office. Oral surgeon/dentist professional fees are not covered. The following are examples, though not all-inclusive, of medical conditions which may require hospitalization for dental services: severe asthma, severe airway obstruction or hemophilia. Except as listed above, hospitalization required due to the behavior of the Covered Person or due to the extent of the dental procedure is not covered.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Medical Complications of Dental Care. The Plan covers certain medical complications of dental care. Treatment must be medically necessary care and related to significant medical complications of non-covered dental care, including complications of the head, neck, or substructures.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Oral Surgery. The Plan covers certain oral surgery. Coverage is limited to treatment of medical conditions requiring oral surgery, such as treatment of oral neoplasm, non-dental cysts, fracture of the jaws and trauma of the mouth and jaws.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Orthognathic Surgery Benefit. The Plan covers orthognathic surgery for the treatment of severe skeletal dysmorphia where a functional occlusion cannot be achieved through non-surgical treatment alone and where a demonstrable functional impairment exists. Functional impairments include but are not limited to significant impairment in chewing, breathing or swallowing. Associated dental or orthodontic services (pre- or post-operatively including surgical rapid palatal expansion) are not covered as a part of this benefit.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	No coverage.

Treatment of Cleft Lip and Cleft Palate. The Plan covers certain treatment of cleft lip and cleft palate of a dependent child, to the limiting age in the definition of an “Eligible Dependent,” including orthodontic treatment and oral surgery directly related to the cleft. Benefits for individuals up to age 26 for coverage of the dependent are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. Dental services which are not necessary for the treatment of cleft lip or cleft palate are not covered. If a dependent child covered under the Plan is also covered under a dental plan which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same copayment, conditions and limitations as durable medical equipment.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD). The Plan covers surgical and non-surgical treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD), when such care is medically necessary. Dental services which are not required to directly treat TMD or CMD are not covered.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

DIAGNOSTIC IMAGING SERVICES

Covered Services:

The Plan covers diagnostic imaging, when ordered by a provider and provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under “Hospital and Skilled Nursing Facility Services”).

For Network Benefits, non-emergency, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) must be provided at a designated facility.

Associated with Covered Preventive Services (MRI/CT Procedures are not Considered Preventive)

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

Services for Illness or Injury

Outpatient Magnetic Resonance Imaging (MRI) and Computed Tomography (CT)

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

All Other Outpatient Diagnostic Imaging Services

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

Covered Services:

The Plan covers equipment and services, as described below.

The Plan covers durable medical equipment and services, prosthetics, orthotics, and supplies, subject to the limitations below, including certain disposable supplies, enteral feedings and the following diabetic supplies and equipment: glucose monitors, insulin pumps, syringes, blood and urine test strips and other diabetic supplies as deemed medically appropriate and necessary, for Covered Persons with gestational, Type I or Type II diabetes.

External hearing aids (including osseointegrated or bone anchored) for Covered Persons age 18 or younger who have hearing loss that is not correctable by other covered procedures. Coverage is limited to one basic, standard hearing aid for each ear every three years. A basic hearing aid is defined as a hearing device that consists of a microphone, amplifier, volume control, battery and receiver. It does not include upgrades above and beyond the functionality of a basic hearing aid, including, but not limited to, hearing improvements for group settings, background noise, Bluetooth/remote control functionality or extended warranties. Charges for upgrades above the cost of a basic, standard hearing aid are not covered.

Diabetic Supplies Purchased at a Pharmacy

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

Diabetic Supplies Purchased from a Non-Pharmacy Provider

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible, if purchased from an approved vendor.	55% of the charges incurred, after you pay the deductible.

Special Dietary Treatment for Phenylketonuria (PKU) if it meets the Medical Coverage Criteria

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

Oral Amino Acid Based Elemental Formula if it meets the Medical Coverage Criteria

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

All Other Durable Medical Equipment, Prosthetics, Orthotics and Supplies

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Limitations:

Coverage of durable medical equipment is limited by the following:

- No more than a 93-day supply of diabetic supplies is covered and dispensed at a time.
- Payment will not exceed the cost of an alternate piece of equipment or service that is effective and medically necessary.
- Hair prostheses (wigs) for hair loss resulting from alopecia areata are limited to one per calendar year.
- For prosthetic benefits, other than hair prostheses (wigs) for hair loss resulting from alopecia areata and oral appliances for cleft lip and cleft palate, payment will not exceed the cost of an alternate piece of equipment or service that is effective, medically necessary and enables Covered Persons to conduct standard activities of daily living.
- The Plan reserves the right to determine if an item will be approved for rental vs. purchase.
- The Plan requires that certain diabetic supplies and equipment be purchased at a pharmacy.
- Diabetic supplies and equipment are limited to certain models and brands.

- Durable medical equipment and supplies must be obtained from or repaired by approved vendors.
- Covered Services and supplies are based on established medical policies which are subject to periodic review and modification by the medical directors. The coverage policy for diabetic supplies includes information on the required models and brands. The Medical Coverage Criteria are available by calling Member Services, or logging on to your “myHealthPartners” account at healthpartners.com.

Not Covered:

Items which are not eligible for coverage include, but are not limited to:

- Replacement or repair of any covered items, if the items are (1) damaged or destroyed by misuse, abuse or carelessness, (2) lost; or (3) stolen.
- Duplicate or similar items.
- Labor and related charges for repair of any covered items which are more than the cost of replacement by an approved vendor.
- Sales tax, mailing, delivery charges, service call charges.
- Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience or recreation.
- Communication aids or devices: equipment to create, replace or augment communication abilities including, but not limited to, speech processors, receivers, communication boards, or computer or electronic assisted communication.
- Hearing aids (implantable and external, including osseointegrated or bone anchored) and their fitting, except as specifically described in this SPD. This exclusion does not apply to cochlear implants.
- Eyeglasses, contact lenses and their fitting, measurement and adjustment, except as specifically described in this SPD.
- Household equipment which primarily has customary uses other than medical, such as, but not limited to, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds.
- Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas.
- Modifications to the structure of the home including, but not limited to, wiring, plumbing or charges for installation of equipment.
- Vehicle, car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carriers.
- Rental equipment while owned equipment is being repaired by non-contracted vendors, beyond one month rental of medically necessary equipment.
- Other equipment and supplies, including but not limited to assistive devices, that we determine are not eligible for coverage.
- Please refer to the “SERVICES NOT COVERED” section.

EMERGENCY AND URGENTLY NEEDED CARE SERVICES

Covered Services:

The Plan covers services for emergency care and urgently needed care if the services are otherwise eligible for coverage under this SPD.

Urgently Needed Care. These are services to treat an unforeseen illness or injury, which are required in order to prevent a serious deterioration in the Covered Person's health, and which cannot be delayed until the next available clinic hours.

Urgently Needed Care at Clinics

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible. The first three mental and chemical health visits, urgent care visits, office visits, convenience clinic visits, telephone visits and e-visits (other than virtuwell) combined in a calendar year are covered at 100%, not subject to the deductible. Physician's services are included; however, charges for day treatment services, group visits, office procedures, laboratory, radiology and other ancillary services are not included and will be subject to your deductible and coinsurance.	See Network Benefits.

Emergency Care. These are services to treat: (1) the sudden, unexpected onset of illness or injury which, if left untreated or unattended until the next available clinic or office hours, would result in hospitalization; or (2) a condition requiring professional health services immediately necessary to preserve life or stabilize health.

When reviewing claims for coverage of emergency services, a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next working day or next available clinic appointment will be taken into consideration.

The Plan **must be** notified within two working days of admission to a non-network hospital, or as soon as reasonably possible under the circumstances.

Emergency Care in a Hospital Emergency Room, including Professional Services of a Physician

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	See Network Benefits.

Inpatient Emergency Care in a Hospital

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible. Non-Network professional fees will be paid at the Network Inpatient Hospital Services Benefit level if the Covered Person is admitted inpatient to a network hospital through the emergency room.	See Network Benefits.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

GENE THERAPY

Covered Services:

The Plan covers gene therapy treatment that meets the Medical Coverage Criteria.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
Coverage level is same as corresponding Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	No coverage.

Limitations:

- Gene Therapy must be provided by a designated provider.
- Specific types of gene therapy are limited to therapies and conditions specified in the Medical Coverage Criteria.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

HEALTH EDUCATION

Covered Services:

The Plan covers education for preventive services and education for the management of chronic health problems (such as diabetes).

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	No coverage.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

HOME HEALTH SERVICES

Covered Services:

The Plan covers skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy and other therapeutic services, non-routine prenatal and postnatal services, routine postnatal well child visits as described in the Medical Coverage Criteria, phototherapy services for newborns, home health aide services and other eligible home health services when rendered in the Covered Person's home if the Covered Person is homebound (i.e., unable to leave home without considerable effort due to a medical condition). Lack of transportation does not constitute homebound status. For phototherapy services for newborns and high risk prenatal services, supplies and equipment are included.

The Plan covers total parenteral nutrition/intravenous (“TPN/IV”) therapy, equipment, supplies and drugs in connection with IV therapy. IV line care kits are covered under Durable Medical Equipment.

You do not need to be homebound to receive total parenteral nutrition/intravenous (“TPN/IV”) therapy.

The Plan covers palliative care benefits. Palliative care includes symptom management, education and establishing goals for care. The requirement that the Covered Person is homebound will be waived for a limited number of home visits for palliative care, if you have a life-threatening, non-curable condition which has a prognosis of two years or less. Additional palliative care visits are eligible under the home health services benefit if you are homebound and meet all other requirements defined in this section.

Home health services are eligible and covered only when:

- medically necessary; and
- provided as rehabilitative care, terminal care or maternity care; and
- ordered by a physician, and included in the written home care plan.

Limitations:

Home health services are not provided as a substitute for a primary caregiver in the home or as relief (respite) for a primary caregiver in the home. The Plan will not reimburse family members or residents in the Covered Person's home for the above services.

A service shall not be considered a skilled nursing service merely because it is performed by, or under the direct supervision of, a licensed nurse. Where a service (such as tracheotomy suctioning or ventilator monitoring or like services) can be safely and effectively performed by a non-medical person (or self-administered), without the direct supervision of a licensed nurse, the service shall not be regarded as a skilled nursing service, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it a skilled service when a skilled nurse provides it. Only the skilled nursing component of so-called “blended” services (i.e., services which include skilled and non-skilled components) are covered under the Plan.

Physical Therapy, Occupational Therapy, Speech Therapy, Respiratory Therapy, Home Health Aide Services and Palliative Care

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

TPN/IV Therapy, Skilled Nursing Services, Non-Routine Prenatal/Postnatal Services, and Phototherapy

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Each 24-hour visit (or shifts of up to 24-hour visits) equals one visit and counts toward the maximum visits for all other services shown below. Any visit that lasts less than 24 hours, regardless of the length of the visit, will count as one visit toward the maximum visits for all other services shown below. All visits must be medically necessary and benefit eligible.

Maximum Visits for Palliative Care

If you are eligible to receive palliative care in the home and you are not homebound, there is a maximum of 12 visits per calendar year.

Maximum Visits for all other Services

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
For all other services that meet the home health services requirements described in the SPD, there is a maximum of 120 visits per calendar year.	For all other services that meet the home health services requirements described in the SPD, there is a maximum of 60 visits per calendar year.

Each visit provided under the Network Benefits and Non-Network Benefits, combined, counts toward the maximums shown above.

Routine Postnatal Well Child Visits

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

The routine postnatal well child visits do not count toward the visit limits above.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

HOME HOSPICE SERVICES

Covered Services:

Home Hospice Program. The Plan covers the services described below for Covered Persons who are terminally ill patients and accepted as home hospice program participants. Covered Persons must meet the eligibility requirements of the program, and elect to receive services through the home hospice program. The services will be provided in the patient's home, with inpatient care available when medically necessary as described below. Covered Persons who elect to receive hospice services do so in lieu of curative treatment for their terminal illness for the period they are enrolled in the home hospice program.

Eligibility: In order to be eligible to be enrolled in the home hospice program, a Covered Person must: (1) be a terminally ill patient (prognosis of six months or less); (2) have chosen a palliative treatment focus (i.e., emphasizing comfort and supportive services rather than treatment attempting to cure the disease or condition); and (3) continue to meet the terminally ill prognosis as determined by HealthPartners medical director or his or her designee over the course of care. A Covered Person may withdraw from the home hospice program at any time.

Eligible Services: Hospice services include the following services provided by Medicare-certified providers, if provided in accordance with an approved hospice treatment plan.

- **Home Health Services:**
 - Part-time care provided in the Covered Person's home by an interdisciplinary hospice team (which may include a physician, nurse, social worker, and spiritual counselor) and medically necessary home health services are covered.
 - One or more periods of continuous care in the Covered Person's home or in a setting which provides day care for pain or symptom management, when medically necessary, will be covered.
- **Inpatient Services:** The Plan covers medically necessary inpatient services.
- **Other Services:**
 - Respite care is covered for care in the Covered Person's home or in an appropriate facility, to give the patient's primary caregivers (i.e., family members or friends) rest and/or relief when necessary in order to maintain a terminally ill patient at home.
 - Medically necessary medications for pain and symptom management.
 - Medically necessary semi-electric hospital beds and other durable medical equipment are covered.
 - Medically necessary emergency and non-emergency care are covered.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
<p>75% of the charges incurred, after you pay the deductible.</p> <p>Respite care is limited to five days per episode, and respite care and continuous care combined are limited to 30 days.</p>	<p>No coverage.</p>

Terms Specific to the Home Hospice Benefit:

Part-time: This is up to two hours of service per day; more than two hours is considered continuous care.

Continuous Care: This is from two to 12 hours of service per day provided by a registered nurse, licensed practical nurse, or home health aide, during a period of crisis in order to maintain a terminally ill patient at home.

Appropriate Facility: This is a nursing home, hospice residence, or other inpatient facility.

Custodial Care Related to Hospice Services: This means providing assistance in the activities of daily living and the care needed by a terminally ill patient which can be provided by a primary caregiver (i.e., family member or friend) who is responsible for the patient's home care.

Not Covered:

- Financial or legal counseling services.
- Housekeeping or meal services in the patient's home.
- Custodial care related to hospice services, whether provided in the home or in a nursing home.
- Any service not specifically described as a Covered Service under this “Home Hospice Services” section.
- Any services provided by a member of the patient's family or resident in the Covered Person's home.
- Please refer to the “SERVICES NOT COVERED” section.

HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Covered Services:

The Plan covers services as described below.

Medical or Surgical Hospital Services

Inpatient Hospital Services. The Plan covers the following medical or surgical services, for the treatment of acute illness or injury, which require the level of care only provided in an acute care facility. These services must be authorized by a physician.

Inpatient hospital services include: room and board; the use of operating or maternity delivery rooms; intensive care facilities; newborn nursery facilities; general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, prescription drugs or other medications administered during treatment, blood and blood products (unless replaced) and blood derivatives, and other diagnostic or treatment related hospital services; physician and other professional medical and surgical services provided while in the hospital, including gender reassignment surgery that meets the Medical Coverage Criteria.

The Plan covers up to 120 hours of services provided by a private duty nurse or personal care assistant who has provided home care services to a ventilator-dependent patient, solely for the purpose of assuring adequate training of the hospital staff to communicate with that patient.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Plan Sponsor.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Each Covered Person's admission or confinement, including that of a newborn child, is separate and distinct from the admission or confinement of any other Covered Person.

Outpatient Hospital, Ambulatory Care or Surgical Facility Services. The Plan covers the following medical and surgical services, for diagnosis or treatment of illness or injury on an outpatient basis. These services must be authorized by a physician.

Outpatient services include: use of operating rooms, maternity delivery rooms or other outpatient departments, rooms or facilities; and the following outpatient services: general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, drugs administered during treatment, blood and blood products (unless replaced) and blood derivatives, and other diagnostic or treatment related outpatient services; physician and other professional medical and surgical services rendered while an outpatient, including gender reassignment surgery that meets the Medical Coverage Criteria.

For Network Benefits, non-emergency, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) must be provided at a designated facility.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

To see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see benefits under “Diagnostic Imaging Services,” “Laboratory Services” and “Physical Therapy” in this Benefits Chart.

Skilled Nursing Facility Care. The Plan covers room and board, daily skilled nursing and related ancillary services for post-acute treatment and rehabilitative care of illness or injury that meets the Medical Coverage Criteria.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.
Limited to 120 day maximum per calendar year.	Limited to 120 day maximum per calendar year.

Each day of services provided under the Network Benefits and Non-Network Benefits, combined, counts toward the maximums shown above.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

INFERTILITY SERVICES

Covered Services:

The Plan covers certain professional services, for the diagnosis and treatment of infertility, medically necessary tests, facility charges and laboratory work related to Covered Services.

Covered Services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. The Medical Coverage Criteria and applicable prior authorization requirements are available by logging on to your “myHealthPartners” account at healthpartners.com or by calling Member Services.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Infertility services for Network Benefits and Non-Network Benefits are limited to a combined \$5,000 calendar year maximum benefit. Drugs for the treatment of infertility are not subject to this maximum.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

LABORATORY SERVICES

Covered Services:

The Plan covers laboratory tests when ordered by a provider and provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under “Hospital and Skilled Nursing Facility Services”).

Associated with Covered Preventive Services

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

For Illness or Injury

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

MASTECTOMY RECONSTRUCTION BENEFIT

Covered Services:

The Plan covers reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce symmetrical appearance, prostheses and treatment for physical complications during all stages of mastectomy, including lymphedemas.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
Coverage level is same as corresponding Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Non-Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

MEDICATION THERAPY DISEASE MANAGEMENT PROGRAM

Covered Services:

If you meet criteria for coverage, you may qualify for the Medication Therapy Disease Management Program.

The Program covers consultations with a designated network pharmacist.

Covered Services are based on established medical policies, which are subject to periodic review and modification by the medical directors. The Medical Coverage Criteria are available by logging on to your “myHealthPartners” account at healthpartners.com or by calling Member Services.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	No coverage.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

OFFICE VISITS FOR ILLNESS OR INJURY

Covered Services:

The Plan covers the following when medically necessary: professional medical and surgical services and related supplies, including biofeedback, of physicians and other health care providers, and blood and blood products (unless replaced) and blood derivatives.

The Plan also covers diagnosis and treatment of illness or injury to the eyes. Where contact or eyeglass lenses are prescribed as medically necessary for the post-operative treatment of cataracts or for the treatment of aphakia or keratoconus, the initial evaluation, lenses and fitting are covered under the Plan. Covered Persons must pay for lens replacement beyond the initial pair.

The Plan also provides coverage for the initial physical evaluation of a child if it is ordered by a Minnesota juvenile court.

Office Visits

<p><u>Network Benefits</u> 75% of the charges incurred, after you pay the deductible.</p>	<p><u>Non-Network Benefits</u> 55% of the charges incurred, after you pay the deductible.</p>
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Convenience Clinics

<p><u>Network Benefits</u> 75% of the charges incurred, after you pay the deductible.</p>	<p><u>Non-Network Benefits</u> 55% of the charges incurred, after you pay the deductible.</p>
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Scheduled Telephone Visits

<p><u>Network Benefits</u> 75% of the charges incurred, after you pay the deductible.</p>	<p><u>Non-Network Benefits</u> 55% of the charges incurred, after you pay the deductible.</p>
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E-visits

Access to Online Care through [virtuwell](http://virtuwell.com) at virtuwell.com

<p><u>Network Benefits</u> The first three visits to virtuwell in a calendar year are paid at 100%, not subject to the deductible. Then all virtuwell services will be covered at 75% of the charges incurred. Deductible applies.</p>	<p><u>Non-Network Benefits</u> Not applicable.</p>
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All Other E-visits

<p><u>Network Benefits</u> 75% of the charges incurred, after you pay the deductible.</p>	<p><u>Non-Network Benefits</u> 55% of the charges incurred, after you pay the deductible.</p>
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For Network Benefits, the first three mental and chemical health visits, urgent care visits, office visits, convenience clinic visits, telephone visits and e-visits (other than [virtuwell](http://virtuwell.com)) combined in a calendar year are covered at 100%, not subject to the deductible. Physician’s services are included; however, charges for day treatment services, group visits, office procedures, laboratory, radiology and other ancillary services are not included and will be subject to your deductible and coinsurance.

Injections Administered in a Physician’s Office, other than Immunizations

Allergy Injections

<p><u>Network Benefits</u> 75% of the charges incurred, after you pay the deductible.</p>	<p><u>Non-Network Benefits</u> 55% of the charges incurred, after you pay the deductible.</p>
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All Other Injections

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

PEDIATRIC AUTOIMMUNE NEUROPSYCHIATRIC DISORDERS ASSOCIATED WITH STREPTOCOCCAL INFECTIONS AND PEDIATRIC ACUTE-ONSET NEUROPSYCHIATRIC SYNDROME TREATMENT

Covered Services:

The Plan covers treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS). Treatments that must be covered under this section must be recommended by the Covered Person’s licensed health care professional and include, but are not limited to, antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
Coverage level is same as corresponding Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Non-Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

Terms Specific to this Benefit:

Pediatric acute-onset neuropsychiatric syndrome: This means a class of acute-onset obsessive compulsive or tic disorders or other behavioral changes presenting in children and adolescents that are not otherwise explained by another known neurologic or medical disorder.

Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections: This means a condition in which a streptococcal infection in a child or adolescent causes the abrupt onset of clinically significant obsessions, compulsions, tics, or other neuropsychiatric symptoms or behavioral changes, or a relapsing and remitting course of symptom severity.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY

Covered Services:

The Plan covers the following physical therapy, occupational therapy and speech therapy services provided in clinic. The Plan also covers physical therapy provided in an outpatient hospital facility. To see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under “Hospital and Skilled Nursing Facility Services.”

- Rehabilitative care to correct the effects of illness or injury.
- Habilitative care rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development.

Massage therapy which is performed in conjunction with other treatment/modalities by a physical or occupational therapist and is part of a prescribed treatment plan and is not billed separately is covered.

Rehabilitative Therapy

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible. Physical and Occupational therapy combined are limited to 20 visits per calendar year. Speech therapy is limited to 20 visits per calendar year.

Habilitative Therapy

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible. Physical, Occupational and Speech therapy, combined, are limited to 20 visits per calendar year.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

PRE-DIABETES DISEASE MANAGEMENT PROGRAM

Covered Services:

If you meet criteria for coverage, you may qualify for the Pre-Diabetes Disease Management Program.

The program covers group health coaching which focuses on weight loss, exercise, behavior modification and health education at select locations determined by the Plan.

Eligibility for participation in the program is based on established medical policies, which are subject to periodic review and modification by the medical directors. The Medical Coverage Criteria are available by logging on to your “myHealthPartners” account at healthpartners.com or by calling Member Services.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	No coverage.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

PRESCRIPTION DRUG SERVICES

Covered Services:

The Plan covers prescription drugs and medications, which can be self-administered or are administered in a physician’s office.

The Plan covers orally administered anticancer drugs at the applicable benefit level under outpatient drugs below. The Plan is in compliance with Minnesota Statute 62.A3075 because the Plan does not cover orally administered anticancer drugs under the specialty drug benefit.

HealthPartners will refill a prescription for eye drops covered under this Plan if the Covered Person requests a refill and the original prescription specified that additional quantities would be needed, providing the refill request does not exceed the quantities needed, and the following conditions are met:

- If the Covered Person requests a 30-day refill supply, the request must be made between 21 and 30 days of the later of (1) the original date that the prescription was distributed to the Covered Person or (2) the date that the most recent refill was distributed to the Covered Person; or
- If the Covered Person requests a 90-day refill supply, the request must be made between 75 and 90 days of the later of (1) the original date that the prescription was distributed to the member or (2) the date that the most recent refill was distributed to the Covered Person.

For Network Benefits, drugs and medications must be obtained at a Network Pharmacy.

Outpatient Drugs (except as specified below)

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
\$12 copayment and 100% thereafter per prescription for generic formulary drugs.	55% of the charges incurred, after you pay the deductible.
\$35 copayment and 100% thereafter per prescription for brand name formulary drugs.	
\$50 copayment and 100% thereafter per prescription for non-formulary drugs.	
Deductible does not apply.	

Cost Sharing Limits for Insulin: The Plan is required to limit your cost-sharing on prescription insulin to no more than the net price of the prescription insulin drug. This requirement applies at the point of sale, including deductible payments and the cost-sharing amounts charged once the deductible is met.

Cost-sharing: This means a deductible payment, copayment, or coinsurance amount that you must pay for covered prescription insulin in accordance with the terms and conditions of this Plan.

Net price: This means HealthPartners' cost for prescription insulin, including any rebates or discounts received by or accrued directly or indirectly to HealthPartners from a drug manufacturer or pharmacy benefits manager.

Mail Order Drugs

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
You may also get outpatient prescription drugs that can be self-administered through HealthPartners mail order service. Outpatient drugs ordered through this service are covered at the benefit percent shown in Outpatient Drugs above, subject to two copayments for each 93-day supply or portion thereof. Deductible does not apply.	Mail order drugs are only available through HealthPartners mail order service. See Network Benefits.
Specialty drugs are not available through the mail order service.	

Tobacco Cessation Drugs

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
<p>100% of the charges incurred. Deductible does not apply.</p> <p>All FDA-approved tobacco cessation drugs (including over-the-counter drugs) are covered and must be prescribed by a licensed provider.</p>	<p>No coverage.</p>

Drugs for Treatment of Infertility

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
<p>75% of the charges incurred. Deductible does not apply.</p> <p>Infertility drugs must be obtained from a designated vendor.</p> <p>Drugs for the treatment of infertility are subject to a \$3,000 maximum benefit per calendar year.</p>	<p>55% of the charges incurred, after you pay the deductible.</p>

Diabetic Supplies Purchased at a Pharmacy

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
<p>75% of the charges incurred. Deductible does not apply.</p>	<p>55% of the charges incurred, after you pay the deductible.</p>

Specialty Drugs that are Self-Administered

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
<p>\$12 copayment and 100% thereafter per prescription for generic formulary drugs.</p> <p>\$35 copayment and 100% thereafter per prescription for brand name formulary drugs.</p> <p>\$50 copayment and 100% thereafter per prescription for non-formulary drugs.</p> <p>Deductible does not apply.</p> <p>For Network Benefits, specialty drugs are limited to drugs on the Specialty Drug List and must be obtained from a designated vendor.</p>	<p>55% of the charges incurred, after you pay the deductible.</p>

In order for the Plan to better manage available manufacturer-funded copayment assistance, copayments for certain specialty medications may vary and be set to approximate the maximum of any available manufacturer-funded copayment assistance programs. However, in no case will true out-of-pocket costs to the Covered Person be greater than the maximum copayment/coinsurance shown in this Benefits Chart. Manufacturer-funded copayment assistance received by a Covered Person will not apply to the Covered Person’s annual deductible or out-of-pocket limit.

Drugs for the Treatment of Growth Deficiency

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred. Deductible does not apply. For Network Benefits, growth deficiency drugs are limited to drugs on the Specialty Drug List and must be obtained from a designated vendor.	55% of the charges incurred, after you pay the deductible.

Contraceptive Drugs

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
Formulary contraceptives are covered at 100% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

Drugs for Breast Cancer Prevention (for women at high risk for breast cancer who have not yet been diagnosed with the disease)

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

Limitations:

- Certain drugs may require prior authorization as indicated on the formulary. The Plan may require prior authorization for the drug and also the site where the drug will be provided. Certain drugs are subject to HealthPartners utilization review process and quantity limits, as indicated on the formulary.
- Certain non-formulary drugs require prior authorization. In addition, certain drugs may be subject to any quantity limits applied as part of the trial program. The trial drug program applies to new prescriptions for certain drugs which have high toxicity, low tolerance, high costs and/or high potential for waste. Trial drugs are indicated on the formulary and/or the Specialty Drug List. Your first fill of a trial drug may be limited to less than a month supply. If the drug is well tolerated and effective, you will receive the remainder of your first month supply.
- HealthPartners may require Covered Persons to try over-the-counter (OTC) drug alternatives before approving more costly formulary prescription drugs.
- Unless otherwise specified above in the “Prescription Drug Services” section, you may receive up to a 31-day supply per prescription.
- A 93-day supply will be covered and dispensed at a time only at pharmacies that participate in the HealthPartners extended day supply program.
- New prescriptions to treat certain chronic conditions are limited to a 31-day supply.
- No more than a 31-day supply of specialty drugs will be covered and dispensed at a time, unless it’s a manufacturer supplied drug that cannot be split that supplies the Covered Person with more than a 31-day supply.
- Drugs on the Excluded Drug List are not covered. The Excluded Drug List includes select drugs within a therapy class that are not eligible for coverage. This includes drugs that may be excluded for certain indications. You can find the Excluded Drug List if you go to healthpartners.com, select Pharmacy and select any of the formularies.
- Medical devices approved by the FDA will not be covered under the “Prescription Drug Services” section unless they are listed on the formulary. Covered medical devices may be covered under other medical benefits.
- Outpatient drugs for the treatment of male sexual dysfunction are limited to six doses per month.
- Drugs for the treatment of male sexual dysfunction ordered through the HealthPartners mail order service are limited 18 doses per 93-day supply.

- If you request a brand name drug when there is a generic equivalent, the brand name drug will be covered up to the charge that would apply to the generic drug, minus any required copayment.
- If a physician requests that a brand name drug be dispensed as written (DAW), the drug will be paid at the non-formulary benefit.
- If a copayment is required, you must pay one copayment for each 31-day supply or portion thereof, except for mail order drugs, see benefit above.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

PREVENTIVE SERVICES

Applicable Definitions:

Routine Preventive Services are routine healthcare services that include screenings, check-ups and counseling to prevent illness, disease or other health problems before symptoms occur.

Diagnostic Services are services to help a provider understand your symptoms, diagnose illness and decide what treatment may be needed. They may be the same services listed as preventive services, but they are being used as diagnostic services. Your provider will determine if these services are preventive or diagnostic. These services are not preventive if received as part of a visit to diagnose, manage or maintain an acute or chronic medical condition, illness or injury. When that occurs, standard deductibles, copayments or coinsurance apply.

Covered Services:

Covered Services are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. The Medical Coverage Criteria are available by logging on to your “myHealthPartners” account at healthpartners.com or by calling Member Services.

The Plan covers preventive services which meet any of the requirements under the Affordable Care Act (ACA) shown in the bulleted items below. These preventive services are covered at 100% under the Network Benefits with no deductible, copayments or coinsurance. If a preventive service is not required by the ACA and it is covered at a lower benefit level, it will be specified below. Preventive benefits mandated under the ACA are subject to periodic review and modification. Changes will be effective in accordance with the federal rules. Preventive services mandated by the ACA include:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual;
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

ACA and state mandated preventive services are covered as follows:

Routine Health Exams and Periodic Health Assessments. A physician or health care provider will counsel Covered Persons as to how often health assessments are needed based on age, sex and health status of the Covered Person. This includes screening and counseling for tobacco use and all FDA approved tobacco cessation medications including over-the-counter drugs (as shown in the “Prescription Drug Services” section).

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

Child Health Supervision Services. This includes pediatric preventive services such as newborn screenings, appropriate immunizations, developmental assessments and laboratory services appropriate to the age of the child from birth to 72 months and appropriate immunizations to age 18.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

Routine Prenatal Care and Exams

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

Routine Postnatal Care. This includes health exams, assessments, education and counseling relating to the period immediately after childbirth.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

Routine Screening Procedures for Cancer. This includes colorectal screening or other cancer screenings recommended by the USPSTF with an A or B rating. “Women’s Preventive Health Services” below describes additional routine screening procedures for cancer.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

Professional Voluntary Family Planning Services. This includes services to prevent or delay a pregnancy, including counseling and education. Services must be provided by a licensed provider.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

Adult Immunizations

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

Women’s Preventive Health Services. This includes mammograms, screenings for cervical cancer (pap smears), breast pumps, human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus (HIV) and all FDA approved contraceptive methods as prescribed by a physician, sterilization procedures, education and counseling. (See the “Prescription Drug Services” section for coverage of contraceptive drugs.) For women whose family history is associated with an increased risk for BRCA1 or BRCA2 gene mutations, the Plan covers genetic counseling and BRCA screening without cost sharing, if appropriate and as determined by a physician.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

Obesity Screening and Management. The Plan covers obesity screening and counseling. If you are age 18 or older and have a body mass index of 30 or more, the Plan covers intensive obesity management to help you lose weight. Your primary care physician can coordinate these services.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

Preventive Medications. The Plan covers preventive medications currently recommended by the USPSTF with an A or B rating if they are prescribed by your medical provider and they are listed on the formulary. Preventive medications are subject to periodic review and modification. Changes would be effective in accordance with the federal rules and reflected in the Medical Coverage Criteria for preventive care services.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

In addition to any ACA or state mandated preventive services referenced above, the Plan covers the following eligible services:

Routine Eye Exams

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

Routine Hearing Exams

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

Prostate-Specific Antigen (PSA) Testing

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
100% of the charges incurred. Deductible does not apply.	55% of the charges incurred, after you pay the deductible.

Ovarian Cancer Surveillance Tests for women who are at risk. “At risk for ovarian cancer” means (1) having a family history that includes any of the following: one or more first-degree or second-degree relatives with ovarian cancer, clusters of female relatives with breast cancer or nonpolyposis colorectal cancer; or (2) testing positive for BRCA1 or BRCA2 mutations. “Surveillance tests for ovarian cancer” means annual screening using: CA-125 serum tumor marker testing, transvaginal ultrasound, pelvic examination or other proven ovarian cancer screening tests currently being evaluated by the federal Food and Drug Administration or by the National Cancer Institute.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
Coverage level is same as corresponding Network Benefit, depending on type of service provided, such as Diagnostic Imaging Services, Laboratory Services, Office Visits for Illness or Injury or Preventive Services.	Coverage level is same as corresponding Non-Network Benefit, depending on type of service provided, such as Diagnostic Imaging Services, Laboratory Services, Office Visits for Illness or Injury or Preventive Services.

Limitations:

- Services are not preventive if received as part of a visit to diagnose, manage or maintain an acute or chronic medical condition, illness or injury. When that occurs, unless otherwise indicated above, standard deductibles, copayments or coinsurance apply.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

SPECIFIED NON-NETWORK SERVICES

Covered Services:

The Plan covers the following services, when a Covered Person elects to receive them from a Non-Network Provider, at the same level of coverage the Plan provides when a Covered Person elects to receive the services from a Network Provider:

- Voluntary family planning of the conception and bearing of children.
- The provider visit(s) and test(s) necessary to make a diagnosis of infertility.
- Testing and treatment of sexually transmitted diseases (other than HIV).
- Testing for AIDS and other HIV-related conditions.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury.	See Network Benefits for the services covered.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

TELEMEDICINE BENEFIT

Covered Services:

The Plan covers telemedicine services that meet the Medical Coverage Criteria.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Non-Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

TRANSPLANT SERVICES

Covered Services:

Prior authorization is required prior to consultation to support coordination of care and benefits.

The Plan covers eligible Transplant Services (as defined above) while you are a Covered Person. Transplants that will be considered for coverage are limited to the following:

- Kidney transplants for end-stage disease.
- Cornea transplants for end-stage disease.
- Heart transplants for end-stage disease.
- Lung transplants or heart/lung transplants for: (1) primary pulmonary hypertension; (2) Eisenmenger's syndrome; (3) end-stage pulmonary fibrosis; (4) alpha 1 antitrypsin disease; (5) cystic fibrosis; and (6) emphysema.
- Liver transplants for: (1) biliary atresia in children; (2) primary biliary cirrhosis; (3) post-acute viral infection (including hepatitis A, hepatitis B antigen e negative and hepatitis C) causing acute atrophy or post-necrotic cirrhosis; (4) primary sclerosing cholangitis; (5) alcoholic cirrhosis; and (6) hepatocellular carcinoma.
- Allogeneic bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for: (1) acute myelogenous leukemia; (2) acute lymphocytic leukemia; (3) chronic myelogenous leukemia; (4) severe combined immunodeficiency disease; (5) Wiskott-Aldrich syndrome; (6) aplastic anemia; (7) sickle cell anemia; (8) non-relapsed or relapsed non-Hodgkin's lymphoma; (9) multiple myeloma; and (10) testicular cancer.
- Autologous bone marrow transplants or peripheral stem cell support associated with high-dose chemotherapy for: (1) acute leukemias; (2) non-Hodgkin's lymphoma; (3) Hodgkin's disease; (4) Burkitt's lymphoma; (5) neuroblastoma; (6) multiple myeloma; (7) chronic myelogenous leukemia; and (8) non-relapsed non-Hodgkin's lymphoma.
- Pancreas transplants for simultaneous pancreas-kidney transplants for diabetes, pancreas after kidney, living related segmental simultaneous pancreas kidney transplantation and pancreas transplant alone.

To receive Network Benefits, charges for Transplant Services must be incurred at a designated transplant center.

The transplant-related treatment provided, including the expenses incurred for directly related donor services, shall be subject to and in accordance with the provisions, limitations, maximums and other terms of this SPD.

Medical and hospital expenses of the donor are covered only when the recipient is a Covered Person and the transplant and directly related donor expenses have been prior authorized for coverage. Treatment of medical complications that may occur to the donor are not covered. Donors are not considered Covered Persons, and are therefore not eligible for the rights afforded to Covered Persons under this SPD.

The list of eligible Transplant Services and coverage determinations are based on established medical policies which are subject to periodic review and modification by HealthPartners medical director.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
75% of the charges incurred, after you pay the deductible.	55% of the charges incurred, after you pay the deductible.

Terms Specific to the Transplant Benefit:

Autologous: This is when the source of cells is from the individual's own marrow or stem cells.

Allogeneic: This is when the source of cells is from a related or unrelated donor's marrow or stem cells.

Autologous Bone Marrow Transplant: This is when the bone marrow is harvested from the individual and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is then reinfused (transplanted).

Allogeneic Bone Marrow Transplant: This is when the bone marrow is harvested from a donor and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is reinfused (transplanted).

Autologous/Allogeneic Stem Cell Support: This is a treatment process that includes stem cell harvest from either bone marrow or peripheral blood, tumor ablation with high-dose chemotherapy and/or radiation, stem cell reinfusion, and related care. Autologous/allogeneic bone marrow transplantation and high dose chemotherapy with peripheral stem cell rescue/support are considered to be autologous/allogeneic stem cell support.

Designated Transplant Center: This is any health care provider, group or association of health care providers designated by the Plan to provide Transplant Services, supplies or drugs for specified transplants for Covered Persons.

Transplant Services: This is transplantation (including retransplants) of the human organs or tissue listed above, including all related post-surgical treatment, follow-up care and drugs and multiple transplants for a related cause. Transplant Services do not include other organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, except surgical implantation of an FDA approved Ventricular Assist Device (VAD) or total artificial heart, functioning as a temporary bridge to heart transplantation.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

TRANSPLANT TRAVEL BENEFIT

Covered Services:

The Plan may provide travel and lodging when a Covered Person needs a transplant and a designated transplant center is greater than 100 miles from the Covered Person’s primary address.

Covered Services are based on established medical policies, which are subject to periodic review and modification by the medical directors. The Medical Coverage Criteria are available by logging on to your “myHealthPartners” account at healthpartners.com or by calling Member Services.

When submitting receipts for travel and lodging, the Covered Person will need to attach a letter explaining that the receipts are in conjunction with an authorized organ or bone marrow transplant and include the recipient’s name and member ID number or complete a Lodging and Travel Claim form with the receipts.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
<p>75% of the charges incurred, after you pay the deductible.</p> <p>Expenses for travel and lodging for the Covered Person (the transplant recipient) and one adult companion, or up to two companions for a transplant recipient that is a minor dependent, may be covered up to a maximum benefit of \$10,000 per transplant.</p> <p>Lodging coverage is limited to \$100 per day.</p>	<p>No coverage.</p>

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

WEIGHT LOSS SURGERY OR BARIATRIC SURGERY

Covered Services:

Covered Services are based on established medical policies, which are subject to periodic review and modification by the medical directors. The Medical Coverage Criteria are available by logging on to your “myHealthPartners” account at healthpartners.com or by calling Member Services.

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
Coverage level is same as corresponding Network Benefits, depending on the type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	No coverage.

Not Covered:

- Please refer to the “SERVICES NOT COVERED” section.

SERVICES NOT COVERED

In addition to any other benefit exclusions, limitations or terms specified in this SPD, the Plan will not cover charges incurred for any of the following services, except as specifically described in this SPD:

1. Treatment, procedures, services or drugs which are not medically necessary and/or which are primarily educational in nature or for the vocation, comfort, convenience, appearance or recreation of the Covered Person, including skills training.
2. For Network Benefits, treatment, procedures or services which are not provided by a Network Provider.
3. Procedures, technologies, treatments, facilities, equipment, drugs and devices which are considered investigative, or otherwise not clinically accepted medical services. The Plan considers vagus nerve stimulator treatment for the treatment of depression and Quantitative Electroencephalogram treatment for the treatment of behavioral health conditions to be investigative and does not cover these services. The Plan considers the following transplants to be investigative and does not cover them: surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, non-human organ implants and/or transplants and other transplants not specifically listed in this SPD. While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered.
4. Rest and respite services and custodial care, except as specified under the "Home Hospice Services" benefit. This includes all services, medical equipment and drugs provided for such care.
5. Room and board and care provided in halfway houses, extended care facilities, or comparable facilities, including shelter services, correctional services, detention services, transitional services, group homes, foster care services and wilderness services and residential treatment services (except for psychiatric residential treatment for emotionally disabled children, residential care for the treatment of eating disorders and chemical health treatment in a licensed residential primary treatment center as specified in the "Behavioral Health Services" section).
6. Foster care, adult foster care and any type of family child care provided or arranged by the local state or county.
7. Services associated with non-covered services, including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies.
8. Services from non-medically licensed facilities or providers and services outside the scope of practice or license of the individual or facility providing the service.
9. Cosmetic surgery, cosmetic services and treatments, including drugs, primarily for the improvement of the Covered Person's appearance or self-esteem, including, but not limited to, augmentation procedures, reduction procedures and scar revision. This exclusion does not apply to services for port wine stain removal and reconstructive surgery.
10. Commercial weight loss programs and exercise programs. Weight loss/bariatric surgery is only covered if it is performed by a designated network physician.
11. Dental treatment, procedures or services not listed in this SPD.
12. Vocational rehabilitation and recreational or educational therapy.
13. Health services and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise medically necessary, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) competency evaluations, and adoption studies.
14. Assisted reproduction, including, but not limited to gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), intracytoplasmic sperm injection (ICSI) and/or in-vitro fertilization (IVF), and all charges associated with such procedures; reversal of sterilization; treatment of infertility after reversal of sterilization; artificial insemination when not medically necessary for the treatment of a Covered Person's medically diagnosed infertility; and sperm, ova or embryo acquisition, retrieval or storage.
15. Services related to the establishment of surrogate pregnancy and fees for a surrogate.
16. Vision correction surgeries such as keratotomy and keratorefractive surgeries, including LASIK surgery, except as specifically described in the Medical Coverage Criteria.
17. Eyeglasses, contact lenses and their fitting, measurement and adjustment, except as specifically described in this SPD.

18. Communication aids or devices: equipment to create, replace or augment communication abilities including, but not limited to, speech processors, receivers, communication boards or computer or electronic assisted communication.
19. Hearing aids (implantable and external, including osseointegrated or bone anchored) and their fitting, except as specifically described in this SPD. This exclusion does not apply to cochlear implants.
20. Medical Food. Enteral feedings, unless they are the sole source of nutrition used to treat a life-threatening condition, nutritional supplements, over-the-counter electrolyte supplements and infant formula, except as specified in this SPD. This exclusion does not apply to oral amino acid based elemental formula or other items if they meet the Medical Coverage Criteria.
21. Charges for sales tax.
22. Services provided by a family member of the Covered Person, or a resident in the Covered Person's home.
23. Religious counseling, marital/relationship counseling and sex therapy.
24. Private duty nursing services.
25. Services that are rendered to a Covered Person, who also has other primary insurance coverage for those services and who does not provide the Plan the necessary information to pursue coordination of benefits, as required under the Plan.
26. The portion of a billed charge for an otherwise Covered Service by a provider, which is in excess of the usual and customary charges, or which is either a duplicate charge for a service or charges for a duplicate service.
27. Charges for services (a) for which a charge would not have been made in the absence of insurance or medical plan coverage, or (b) which the Covered Person is not legally obligated to pay, and (c) from providers who waive copayment, deductible and coinsurance payments by the Covered Person.
28. Travel and lodging incidental to travel, regardless if it is recommended by a physician and any travel billed by a provider, except as specified in this SPD under the Transplant Travel Benefit.
29. Health club memberships.
30. Massage therapy for the purpose of a Covered Person's comfort or convenience.
31. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
32. Autopsies.
33. For Network Benefits, charges incurred for transplants, Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) received at facilities which are not designated facilities, or charges incurred for weight loss services provided by a physician who is not a designated physician.
34. Accident related dental services if treatment is (a) provided to teeth which are not sound and natural, (b) to teeth which have been restored, (c) initiated beyond six months from the date of the injury, (d) received beyond the initial treatment or restoration, or (e) received beyond 24 months from the date of injury.
35. Nonprescription (over-the-counter) drugs or medications, including, but not limited to, vitamins, supplements, homeopathic remedies and non-FDA approved drugs, unless listed on the formulary and prescribed by a physician or legally authorized health care provider under applicable state and federal law. This exclusion does not include over-the-counter contraceptives for women as allowed under the Affordable Care Act when the Covered Person obtains a prescription for the item.
36. Charges for elective home births.
37. Professional services associated with substance abuse intervention. A "substance abuse intervention" is a gathering of family and/or friends to encourage a person covered under this SPD to seek substance abuse treatment.
38. Treatment, procedures, or services or drugs which are provided when you are not covered under this Plan.
39. Care that is not rehabilitative in nature and medically necessary for the diagnosis and/or treatment of acute neuromusculoskeletal conditions.
40. Services provided by naturopathic providers.
41. Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
42. Non-medical administrative fees and charges including, but not limited to, medical record preparation charges, appointment cancellation fees, after hours appointment charges, and interest charges.
43. Medical cannabis.

44. Drugs on the Excluded Drug List. The Excluded Drug List includes select drugs within a therapy class that are not eligible for coverage. This includes drugs that may be excluded for certain indications. You can find the Excluded Drug List if you go to healthpartners.com, select Pharmacy and select any of the formularies.
45. Drugs that are newly approved by the FDA until they are reviewed and approved by HealthPartners Pharmacy and Therapeutics Committee.
46. Charges for phone, data, software or mobile applications/apps unless specifically described as covered in the Medical Coverage Criteria for the device or service.
47. Court ordered treatment, except as described under “Mental Health Services” and “Office Visits for Illness and Injury” or as otherwise required by law.
48. Hospital services for items for personal convenience, such as television rental.
49. Oral surgery to remove wisdom teeth.

DEFINITIONS OF TERMS USED

Admission: This is the medically necessary admission to an inpatient facility for the acute care of illness or injury.

Authorized Representative: This is a person appointed by you to act on your behalf in connection with an initial claim, an appeal of an adverse benefit determination, or both. To designate an authorized representative, you must complete and sign the "Appointment of Authorized Representative" form and return it to the Plan Manager. You should specify on the form the extent of the authorized representative's authority. This form is available by logging on to your "myHealthPartners" account at healthpartners.com.

Biosimilar Drugs: A prescription drug, approved by the Food and Drug Administration (FDA), that the FDA has determined is biosimilar to and interchangeable with a biological brand name drug. Biosimilar drugs are not considered generic drugs and are not covered under the generic drug benefit.

Brand Name Drug: A prescription drug approved by the Food and Drug Administration (FDA), that is manufactured, sold, or licensed for sale under a trademark by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired. A few brand name drugs may be covered at the generic drug benefit level if this is indicated on the formulary.

CareCheck[®] Service: This is a pre-certification and utilization management program. It reviews, authorizes and coordinates the appropriateness and quality of care for certain benefits, as covered under the Non-Network Benefits of the Plan.

CareLineSM Service: This is a 24-hour telephone service which employs a staff of registered nurses who are available by phone to assist Covered Persons in assessing their need for medical care, and to coordinate after-hours care, as covered under the Plan.

Clinically Accepted Medical Services: These are techniques or services that have been determined to be effective for general use, based on risk and medical implications. Some clinically accepted medical services are approved only for limited use, under specific circumstances, as more fully described in this SPD.

Convenience Clinic: This is a clinic that offers a limited set of services and does not require an appointment.

Cosmetic Surgery: This is surgery to improve or change appearance (other than reconstructive surgery), which is not necessary to treat a related illness or injury.

Covered Dependent: This is the eligible dependent enrolled in the Plan.

Covered Employee: This is the eligible employee enrolled in the Plan.

Covered Person: This is the eligible and enrolled employee and each of his or her eligible and enrolled dependents covered for benefits under the Plan. When used in this SPD, "you" or "your" has the same meaning as Covered Person.

Covered Service: This is a specific medical or dental service or item, which is medically necessary or dentally necessary and covered by the Plan, as described in this SPD.

Custodial Care: This is a supportive service focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including, but not limited to, bathing, dressing and feeding.

Dentally Necessary: This is care which is limited to diagnostic testing, treatment, and the use of dental equipment and appliances which, in the judgment of a dentist, is required to prevent deterioration of dental health, or to restore dental function. The Covered Person's general medical condition must permit the necessary procedure(s).

Dentist: A duly licensed doctor of dental surgery or dental medicine, lawfully performing a dental service in accordance with governmental licensing privileges and limitations.

Eligible Dependents: These are the persons shown below. A person who is no longer an eligible dependent (as defined below) on a Covered Employee's Plan may qualify for continuation of coverage within the group as provided in the "CONTINUATION OF GROUP COVERAGE" section of this SPD.

Please note, for Covered Dependents who do not meet the definition of either a "qualifying child" or a "qualifying relative" under Internal Revenue Code Section 152, payments made by your Employer under this Plan for Covered Services may result in taxable income to the Covered Employee. Please consult with your Employer or tax advisor regarding your individual situation.

1. **Spouse.** This is a Covered Employee's current legal spouse.
2. **Child.** This is a Covered Employee's (a) natural or legally adopted child (effective from the date of adoption or the date placed for adoption, whichever is earlier); (b) child for whom the Covered Employee or the Covered Employee's spouse is the legal guardian; (c) step-child of the Covered Employee (that is, the child of the Covered Employee's spouse); or (d) a child covered under a valid qualified medical child support order (as the term is defined by applicable law) which is enforceable against a Covered Employee.* In each case the child must be either under 26 years of age or a disabled child, as described below. Coverage will terminate the end of the month in which the child turns age 26.

*A description of the procedures governing qualified medical child support order determinations can be obtained by participants and beneficiaries, without charge, from the Plan Sponsor.

3. **Grandchild.** This is a grandchild of a Covered Employee or a Covered Employee's spouse who resides with and is financially dependent on the covered grandparent. The grandchild must be either under 26 years of age or a disabled child, as described below. Coverage will terminate the end of the month in which the dependent grandchild turns age 26.
4. **Disabled Child.** This Plan covers disabled children. A disabled child is a child who is and continues to be both (a) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability and (b) chiefly dependent upon the employee for support and maintenance, provided proof of such incapacity and dependency is furnished to the Plan Manager by the employee within 31 days of the child's attainment of the limiting age and subsequently as may be required by the Plan Manager, but not more frequently than annually after the two-year period following the child's attainment of the limiting age. Any notice regarding termination of coverage due to attainment of the limiting age will notify you of this right.
5. **Disabled Dependent.** This Plan covers disabled dependents. A disabled dependent is a person who is and continues to be both: (a) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and (b) chiefly dependent upon you for support and maintenance. Disabled dependents are not subject to any pre-existing condition limitations, or insurability, eligibility, or health underwriting approval.

Emergency Accidental Dental Services: These are services required immediately, because of a dental accident.

Enrollment Date: This means the first day of coverage under the health benefit plan or the first day of the waiting period, if earlier.

Facility: This is a licensed medical center, clinic, hospital, skilled nursing facility or outpatient care facility, lawfully providing a medical service in accordance with applicable governmental licensing privileges and limitations.

Fiduciary: The person or organization that has the authority to control and manage the operation and administration of the Plan. The fiduciary has discretionary authority to determine eligibility for benefits and to construe the terms of the Plan.

Formulary: This is a current list, which may be revised from time to time, of formulary prescription drugs, medications, equipment and supplies covered under the Plan as indicated in the Benefits Chart which are covered at the highest benefit level. Some drugs may require prior authorization to be covered as formulary drugs. You may access the formulary, and information on drugs that require prior authorization, by logging on to your "myHealthPartners" account at healthpartners.com or by calling Member Services.

Generic Drug: A prescription drug, approved by the Food and Drug Administration (FDA), that the FDA has determined is comparable to a brand name drug product in dosage form, strength, route of administration, quality, intended use and documented bioequivalence. Generally, generic drugs cost less than brand name drugs. Some brand name drugs may be covered at the generic drug benefit level if this is indicated on the formulary.

Habilitative Care: This is speech, physical or occupational therapy which is rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development. To be considered habilitative, measurable functional improvement and measurable progress must be made toward achieving functional goals, within a predictable period of time toward a Covered Person's maximum potential ability. The determination of whether such measurable progress has been made is within the sole discretion of the Plan's medical director or his or her designee, based on objective documentation.

Health Care Provider: This is any licensed non-physician (excluding naturopathic providers), lawfully performing a medical service in accordance with applicable governmental licensing privileges and limitations, who renders direct patient care to Covered Persons as covered under the Plan.

Home Hospice Program: This is a coordinated program of home-based, supportive and palliative care, for terminally ill patients and their families, to assist with the advanced stages of an incurable disease or condition. The services provided are comfort care and are not intended to cure the disease or medical condition, or to prolong life, in accordance with an approved home hospice treatment plan.

Hospital: This is a licensed facility, lawfully providing medical services in accordance with governmental licensing privileges and limitations, and which is recognized as an appropriate facility under the Plan. A hospital is not a nursing home, or convalescent facility.

Illness: This is a sickness or disease, including all related conditions and recurrences, requiring medically necessary treatment.

Injury: This is an accident to the body, requiring medical treatment.

Inpatient: This is a medically necessary confinement for acute care of illness or injury, other than in a hospital's outpatient department, where a charge for room and board is made by the hospital or skilled nursing facility. The Plan covers a semi-private room, unless a physician recommends that a private room is medically necessary. In the event a Covered Person chooses to receive care in a private room under circumstances in which it is not medically necessary, payment under the Plan toward the cost of the room shall be based on the average semi-private room rate in that facility.

Investigative: As determined by HealthPartners, a drug, device, medical, behavioral health or dental treatment is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or positive effect on health outcomes and will be considered investigative unless all of the following categories of reliable evidence are met:

- There is final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the United States Food and Drug Administration (FDA); and
- The drug or device or medical, behavioral health or dental treatment or procedure is not the subject of ongoing Phase I, II or III clinical trials; and
- The drug, device or medical, behavioral health or dental treatment or procedure is not under study and further studies are not needed (such as post-marketing clinical trial requirements) to determine maximum tolerated dose, toxicity, safety, effect on health outcomes or efficacy as compared to existing standard means of treatment or diagnosis; and
- There is conclusive evidence in major peer-reviewed medical journals demonstrating the safety, effectiveness and positive effect on health outcomes (the beneficial effects outweigh any harmful effects) of the service or treatment when compared to standard established service or treatment. Each article must be of well-designed investigations, using generally acceptable scientific standards that have been produced by nonaffiliated, authoritative sources with measurable results. Case reports do not satisfy this criterion. This also includes consideration of whether a drug is included in one of the standard reference compendia or “Major Peer Reviewed Medical Literature” (defined below) for use in the determination of a medically necessary accepted indication of drugs and biologicals used off-label as appropriate for its proposed use.

Major Peer Reviewed Medical Literature: This means articles from major peer reviewed medical journals that have recognized the drug or combination of drugs' safety and effectiveness for treatment of the indication for which it has been prescribed. Each article shall meet the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or be published in a journal specified by the United States Secretary of Health and Human Services pursuant to United States Code, title 42, section 1395x, paragraph (t), clause (2), item (B), as amended, as acceptable peer review medical literature. Each article must use generally acceptable scientific standards and must not use case reports to satisfy this criterion.

Late Enrollee: This is an eligible employee or dependent who enrolls under the Plan other than during:

- the first period in which the individual is eligible to enroll under the Plan; or
- the Employer’s annual open enrollment period; or
- a Special Enrollment Period.

Maintenance Care: This is supportive services, including skilled or non-skilled nursing care, to assist you when your condition has not improved or has deteriorated significantly over a measurable period of time (generally a period of two months). Care may be determined to be maintenance care regardless of whether your condition requires skilled medical care or the use of medical equipment.

Medically Necessary Care:

1. With respect to services other than mental health services:

This is diagnostic testing and medical treatment and prescription drug use which is medically appropriate to your physical diagnosis for an injury or illness, and preventive services covered in this SPD. Medically necessary care must meet the following criteria:

- it meets clinically accepted medical services and practice parameters of the general medical community; and
- it meets the most appropriate and cost-effective level of medical services, prescription drugs or supplies that can be safely provided. When applied to inpatient care, it further means that the medical symptoms or conditions require that the medical services or supplies cannot be safely provided in a lower level of care setting; and
- it restores or maintains health; or
- it prevents deterioration of your condition; or
- it prevents the reasonably likely onset of a health problem or detects an incipient problem.

To be considered medically necessary care, it must not be maintenance or custodial care, or ineffective care, or otherwise excluded under this SPD. The fact that an authorized Network, or Non-Network, Provider prescribes treatment does not necessarily mean the treatment is covered under this Plan.

2. With respect to mental health services:

This is health care services appropriate, in terms of type, frequency, level, setting, and duration, to the Covered Person's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

- help restore or maintain your health; or
- prevent deterioration of your condition.

The fact that an authorized Network, or Non-Network, Provider prescribes treatment does not necessarily mean the treatment is covered under this Plan.

Medicare: This is the federal government's health insurance program under Social Security Act Title XVIII, as amended. Medicare provides medical benefits to people who are 65 or older, or who are permanently disabled. The program has two parts: Part A and Part B. Part A generally covers the costs of hospitals and extended care facilities. Part B generally covers the costs of professional medical services. Both parts are subject to Medicare deductibles.

Mental Health Professional: This is a psychiatrist, psychologist, or mental health therapist licensed for independent practice, lawfully performing a mental or chemical health service in accordance with governmental licensing privileges and limitations, who renders mental or chemical health services to Covered Persons as covered under the Plan. For inpatient services, these mental health professionals must be working under the order of a physician.

Non-Formulary Drug: This is a prescription drug, approved by the Food and Drug Administration (FDA), that is not on the formulary, is medically necessary and is not investigative or otherwise excluded under this Plan.

Outpatient: This is medically necessary diagnosis, treatment, services or supplies rendered by a hospital's outpatient department, or a licensed surgical center and other ambulatory facility (other than in a physician's office).

Physician: This is a licensed medical doctor, or doctor of osteopathy, lawfully performing a medical service, in accordance with governmental licensing privileges and limitations who renders medical or surgical care to Covered Persons as covered under the Plan.

Prescription Drug: This is any medical substance for the prevention, diagnosis or treatment of injury, disease or illness approved and/or regulated by the Food and Drug Administration (FDA). It must (1) bear the legend: “Caution: federal law prohibits dispensing without a prescription” or “Rx Only”; and (2) be dispensed only by authorized prescription of any physician or legally authorized health care provider under applicable state law. Drugs that are newly approved by the FDA must be reviewed by HealthPartners Pharmacy and Therapeutics Committee. This process may take up to six months after market availability.

Pre-service Claim: This is any claim for a benefit under a group health plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. The only claims under this Plan that meet this definition are those claims that require pre-certification by CareCheck[®].

Reconstructive Surgery: This is limited to reconstructive surgery, incidental to or following surgery, resulting from injury or illness of the involved part, or to correct a congenital disease or anomaly resulting in functional defect in a dependent child. A functional defect is one that interferes with a Covered Person's ability to perform activities of daily living.

Rehabilitative Care: This is a restorative service, which is provided for the purpose of obtaining significant functional improvement, within a predictable period of time, (generally within a period of two months) toward a patient's maximum potential ability to perform functional daily living activities.

Residential Behavioral Health Treatment Facility: This is a facility licensed under state law for the treatment of mental health or substance use disorders and that provides inpatient treatment of those conditions by, or under the direction of, a physician. The facility provides continuous, 24-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day. A residential behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.

Skilled Nursing Facility: This is a licensed skilled nursing facility, lawfully performing medical services in accordance with governmental licensing privileges and limitations, and which is recognized as an appropriate facility by the Plan, to render inpatient post-acute hospital and rehabilitative care and services to Covered Persons, whose condition requires skilled nursing facility care. It does not include facilities which primarily provide treatment of mental or chemical health.

Specialty Drug List: This is a current list, which may be revised from time to time, of prescription drugs, medications, equipment and supplies, which are typically bio-pharmaceuticals. The purpose of a Specialty Drug List is to facilitate enhanced monitoring of complex therapies used to treat specific conditions. The Specialty Drug List is available by logging on to your “myHealthPartners” account at healthpartners.com or by calling Member Services.

virtuwell: This is an online service that you use to receive a diagnosis and treatment for certain routine conditions, such as a cold and flu, ear pain and sinus infections. You may access the virtuwell website at virtuwell.com.

Waiting Period: This is the period of time that an individual must wait before being eligible for coverage under the Plan.

DISPUTES AND COMPLAINTS

DETERMINATION OF COVERAGE

Eligible services are covered only when medically necessary for the proper treatment of a Covered Person. HealthPartners medical or dental directors, or their designees, make coverage determinations of medical necessity, restrictions on access and appropriateness of treatment, and they make final authorization for Covered Services. In certain circumstances where prior authorization is required for a Covered Service, Covered Persons may be directed by the Plan Manager to the most cost-effective site of care to receive Covered Services. If the site to which the Covered Person is being directed has a higher cost to the Covered Person than the original physician directed site of care, the benefit category with the lower cost to the Covered Person will apply.

Covered prescription drugs are based on requirements established by the HealthPartners Pharmacy and Therapeutics Committee, and are subject to periodic review and modification.

Coverage determinations are based on the Medical Coverage Criteria, which are subject to periodic review and modification by HealthPartners medical or dental directors.

If your claim for medical services was denied based on HealthPartners clinical coverage criteria, you or your provider can discuss the decision with a clinician who reviewed the request for coverage. Call Member Services for assistance.

COMPLAINTS

The Plan has a complaint procedure to resolve complaints and disputes. Complaints should be made in writing or orally. They may concern the provision of care by Network Providers, administrative actions, or claims related to the Plan, including breach, meaning or termination. The complaint system seeks to resolve a dispute which arose during the time of your coverage, or application for coverage.

Complaints must be made to:

HealthPartners
Member Services Department
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 952-883-5000
Outside the metro area: 800-883-2177 (toll-free)

CONDITIONS

RIGHTS OF REIMBURSEMENT AND SUBROGATION

If services are provided or paid for under the Plan to treat an injury or illness caused by the act or omission of another party and you receive full recovery from such party, the Plan Sponsor or its designee has the right to recover the value of those services and payments made. This right shall be by reimbursement and subrogation. The Plan Sponsor or its designee will be entitled to promptly collect the reasonable value of the Plan's subrogation rights from said settlement fund. Full recovery does not include payments made by this Plan to you or on your behalf. The right of subrogation means that the Plan Sponsor or its designee may make claim in your name or the Plan's name against any persons, organizations or insurers on account of such injury or illness.

This right of reimbursement and subrogation applies to any type of recovery from any third party, including, but not limited to, recoveries from tortfeasors, underinsured motorist coverage, uninsured motorist coverage, other substitute coverage or any other right of recovery, whether based on tort, contract, equity or any other theory of recovery.

If you make a claim against a collateral source for damages that include repayment for medical and medically related expenses covered under this Plan, you are required to provide timely notice to the Plan Sponsor or its designee in writing. The Plan's subrogation right will be reduced by a pro rata share of costs, disbursements, reasonable attorney fees and other expenses unless the Plan Sponsor or its designee are separately represented by an attorney. If the Plan Sponsor or its designee are separately represented by an attorney, the Plan Sponsor or its designee may enter into an agreement regarding allocation of costs. If an agreement cannot be reached regarding allocation, the matter shall be submitted to binding arbitration.

The Plan's rights under this part are subject to Minnesota Law. You should consult an attorney for information about the effect of Minnesota Law on the Plan's subrogation rights.

COORDINATION OF BENEFITS

You agree, as a Covered Person, to permit the Plan Manager to coordinate payments under any other medical benefit plans as specified below, which cover you or your dependents. You also agree to provide any information or submit any claims to other medical benefit plans necessary for this purpose. If you fail to provide this information, your claim may be delayed or denied. You agree to authorize the Plan Manager's billing to other medical plans, for purposes of coordination of benefits.

Unless applicable law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under the Plan must provide any facts needed to pay the claim.

1. Applicability.

- a. This Coordination of Benefits (COB) provision applies to the Plan when a Covered Employee or the Covered Employee's Covered Dependent has medical care coverage under more than one plan. "Plan" and "The Plan" are defined below.
- b. If this Coordination of Benefits provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of The Plan are determined before or after those of another plan. The benefits of The Plan:
 - (1) shall not be reduced when, under the order of benefit determination rules, benefits under The Plan are determined before another plan; but
 - (2) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in paragraph 4. below.

2. Definitions.

- a. **"Plan"** is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
 - (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.
- b. **"The Plan"** is the part of the Plan that provides benefits for medical care expenses.
- c. **"Primary Plan/Secondary Plan"** The order of benefit determination rules state whether The Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When The Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When The Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, The Plan may be a Primary Plan as to one or more of the plans and may be a Secondary Plan as to a different plan or plans.

- d. **“Allowable Expense”** is a necessary, reasonable and customary item of expense for medical care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

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

When benefits are reduced under a primary plan because a Covered Person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements.

- e. **“Claim Determination Period”** is a calendar year. However, it does not include any part of a year during which a person has no coverage under The Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

3. Order of Benefit Determination Rules.

- a. **General.** When there is a basis for a claim under The Plan and another plan, The Plan is a Secondary Plan which has its benefits determined after those of another plan, unless:

- (1) the other plan has rules coordinating its benefits with those of The Plan; and
- (2) both those rules and The Plan's rules, in subparagraph b. below, require that The Plan's benefits be determined before those of the other plan.

- b. **Rules.** The order of benefits are determined using the first of the following rules which applies:

- (1) Nondependent/Dependent. The benefits of the plan which cover the person as a Covered Person or subscriber (that is, other than as a dependent) are determined before those of the plan which cover the person as a dependent.
- (2) Dependent Child/Parents not Separated or Divorced. Except as stated in subparagraph b. (3) below, when The Plan and another plan cover the same child as a dependent of different persons, called “parents”:
 - (a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
 - (b) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- (3) Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - (a) first, the plan of the parent with custody of the child;
 - (b) then, the plan of the spouse of the parent with the custody of the child; and

- (c) finally, the plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the medical care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or calendar year during which any benefits are actually paid or provided before the entity has that actual knowledge.
- (4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for medical care expenses of the child, the plans covering the child follow the order of benefit determination rules outlined in subparagraph b. (2).
- (5) Active/Inactive Enrollee. The benefits of a plan which covers a person as a Covered Employee who is neither laid off nor retired (or as that Covered Employee's dependent) are determined before those of a plan which cover that person as a laid off or retired Covered Employee (or as that Covered Employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (6) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered a Covered Person or subscriber longer are determined before those of the plan which covered that person for the shorter term.

4. Effect on the Benefits of this Plan.

- a. **When this Section Applies.** This paragraph 4. applies when, in accordance with paragraph 3. "Order of Benefit Determination Rules," The Plan is a Secondary Plan as to one or more other plans. In that event the benefits of The Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in b. immediately below.
- b. **Reduction in the Plan's Benefits.** The benefits of The Plan will be reduced when the sum of:
 - (1) the benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
 - (2) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of The Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses. When the benefits of The Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of The Plan.
- c. **Benefit Reserve.** The Secondary Plan shall calculate its savings by subtracting the amount that it paid as a Secondary Plan from the amount it would have paid had it been primary "COB Savings." These COB Savings shall be recorded in the benefit reserve for the Covered Person and shall be used by the Secondary Plan to pay any allowable expenses, not otherwise paid, that are incurred by the Covered Person during the Claim Determination Period. As each claim is submitted, the Secondary Plan must:
 - (1) determine its obligation, pursuant to the contract;
 - (2) determine whether a benefit reserve has been recorded for the Covered Person; and
 - (3) determine whether there are any unpaid allowable expenses during that Claim Determination Period.

If there is a benefit reserve, the Secondary Plan shall use the Covered Person's recorded benefit reserve to pay up to 100% of the total allowable expenses incurred during the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero. A new benefit reserve must be created for each Claim Determination Period. (A Claim Determination Period is based on calendar year.)

5. **Right to Receive and Release Needed Information.** Certain facts are needed to apply these COB rules. The Plan Manager has the right to decide which facts are needed. Consistent with applicable state and federal law, the Plan Manager may get needed facts from or give them to any other organization or person, without your further approval or consent. Unless applicable federal or state law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under The Plan must give any facts the Plan Manager needs to pay the claim.
6. **Facility of Payment.** A payment made under another plan may include an amount which should have been paid under The Plan. If it does, the Plan Sponsor may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under The Plan. The Plan Sponsor will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.
7. **Right of Recovery.** If the amount of the payments made by the Plan Sponsor is more than the amount that should have paid under this COB provision, the Plan Manager may recover the excess from one or more of:
 - a. the persons it has paid or for whom it has paid;
 - b. insurance companies; or
 - c. other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

The benefits provided by the Plan do not apply to injury or disease covered by no-fault insurance, employers liability laws (including workers' compensation), and care available or required to be furnished by or through national or state governments or their agencies including care to which a Covered Person is legally entitled and for which facilities are reasonably available for military service-connected conditions or disabilities. Subject to the Plan's rights in "Rights of Reimbursement and Subrogation" above, medically necessary services will be provided upon request and only expenses incurred for medical treatment otherwise covered by the Plan will be paid if the no-fault insurer, employer, or national or state government or its agencies refuse to pay said expenses. You must cooperate with the Plan Manager's program to bill allowable no-fault and workers' compensation claims to the appropriate insurer(s).

MEDICARE AND THE PLAN

The provisions in this section apply to some, but not all, Covered Persons who are eligible for Medicare. They apply in situations where the federal Medicare Secondary Payer Program allows Medicare to be the primary payer of a Covered Person's medical care claims. Consult your Employer to determine whether or not Medicare is primary in your situation.

In general, Medicare is secondary payer for Medicare enrollees who: (1) are active employees and (2) are covered by Medicare because they have reached age 65 when there are 20 or more employees in the group. The Medicare secondary payer rules change from time to time and the most recent rule will be applied.

Medicare is the primary payer:

- For Covered Persons with end stage renal disease, after the 30 month period following the earlier of (1) the month in which the Covered Person begins a regular course of renal dialysis, or (2) the first of the month in which the Covered Person became entitled to Medicare, if the Covered Person received a kidney transplant without first beginning dialysis. This is regardless of the size of the Employer.
- For retirees who are age 65 or over.
- For Covered Persons under age 65, who are covered by Medicare because of disability (other than end stage renal disease), when (1) the Employer employs fewer than 100 employees and the Covered Person or their spouse or parent has group health plan coverage due to current employment, or (2) the Covered Person or their spouse or parent has coverage not due to current employment, regardless of the number of employees of the Employer.

If Medicare is the primary payer, the benefits under the Plan are not intended to duplicate any benefits to which Covered Persons are, or would be, entitled under Medicare. All sums payable under Medicare for services provided pursuant to the Plan shall be payable to and retained by the Plan Sponsor. Each Covered Person shall complete and submit to the Plan such consents, releases, assignments and other documents as may be requested by the Plan Manager in order to obtain or assure reimbursement under Medicare for which Covered Persons are eligible.

If Medicare is the primary payer, the Plan also reserves the right to reduce benefits for any medical expenses covered under the Plan by the amount of any benefits available for such expenses under Medicare. This will be done before the benefits under the Plan are calculated. Charges for services used to satisfy a Covered Person's Medicare Part B deductible will be applied under the Plan in the order received by the Plan. Two or more charges for services received at the same time will be applied starting with the largest first.

If Medicare is the primary payer, the benefits under the Plan will only be reduced to the extent that the Covered Person has actually enrolled in Medicare.

The provisions of this section will apply to the maximum extent permitted by federal or state law. The Plan will not reduce the benefits due any Covered Person due to that Covered Person's eligibility for Medicare where federal law requires that the Plan determine the benefits for that Covered Person without regard to the benefits available under Medicare.

CONTINUATION OF GROUP COVERAGE

As required by the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), if your eligibility for group coverage under the Plan ends because of one of the qualifying events shown below, you may be eligible to continue group coverage as shown below.

- 1. Qualifying Events.** Coverage under the Plan may be continued by a Covered Employee, Covered Dependent spouse and other Covered Dependents, enrolled at the time coverage would otherwise end, or a child born to or placed for adoption with the Covered Employee during the period of continuation coverage, as a result of one of the following qualifying events:
 - a. Termination of employment (except for gross misconduct) of the Covered Employee, or reduction in hours resulting in a loss of group coverage.
 - b. Death of the Covered Employee.
 - c. Divorce or legal separation of the Covered Employee.
 - d. Loss of eligibility as a Covered Dependent child.
 - e. Initial enrollment of the Covered Employee for Medicare.
 - f. For a retired Covered Employee, spouse and other dependents, the bankruptcy filing by a former Employer, under Title XI, United States Code, on or after July 1, 1986.
- 2. Duration of Continuation Coverage.** The maximum period coverage can be continued depends on the qualifying event. Continuation coverage may be terminated earlier as shown below. The maximum period of continuation coverage starts on the day of the qualifying event.
 - a. Maximum period**
 - (1) **Termination and reduced hours.** The maximum period of continuation coverage is 18 months. If a second qualifying event, other than the Employer's bankruptcy, occurs during the 18 months, the maximum period of continuation coverage is 36 months.

- (2) **Disabled Covered Employee, Covered Dependent spouse or Covered Dependent child.** If the Covered Employee, Covered Dependent spouse or other Covered Dependent is disabled under Title II or XVI of the Social Security Act, at the time of the termination of employment, or reduced hours of the Covered Employee, or within the first 60 days of continuation of coverage, the 18-month maximum continuation period may be extended to 29 months. The disabled person must notify the Plan Sponsor within 60 days of the date of determination of disability, and within the initial 18-month continuation period. If a second qualifying event (other than bankruptcy) occurs during the extended 29-month period, the maximum period of continuation coverage is 36 months.
- (3) **Bankruptcy.** In the case of bankruptcy of a retired Covered Employee's former Employer, the maximum period of continuation coverage is until the death of the retired Covered Employee. In the case of the surviving spouse or dependent children of the retired Covered Employee, the maximum period of continuation coverage is 36 months after the death of the retired Covered Employee.
- (4) **Divorce or legal separation.** The maximum period of coverage for a former spouse or dependents who lose coverage due to divorce or legal separation is 36 months.
- (5) **Death of Covered Employee.** The maximum period of coverage for a Covered Dependent surviving spouse and Covered Dependents who lose coverage due to the death of the Covered Employee is 36 months.
- (6) **Other qualifying events.** The maximum period of continuation coverage for all other qualifying events is 36 months.

b. Earlier Termination

Coverage terminates before the end of the maximum period if any of the following occurs.

- (1) **End of the Plan.** The Plan under which this coverage is offered to Covered Employees is terminated.
- (2) **Failure to pay premium.** The person receiving continuation coverage does not make the monthly payment within 30 days of the due date.
- (3) **Other group health coverage.** The person receiving continuation coverage becomes covered under any other group health type coverage, not containing an exclusion or limitation for any pre-existing condition of the person. If the other group health coverage contains a pre-existing condition limitation, continuation coverage is extended until the pre-existing limitation is satisfied or coverage is otherwise terminated. A person will not be subject to earlier termination of continuation coverage on account of coverage under another group plan that existed prior to that person's first day of continuation coverage.
- (4) **Termination of extended coverage for disability.** In case a person receives extended (29-month) continuation coverage due to disability at the time of termination or reduced hours, the extended coverage terminates at the beginning of the month 30 days after a final determination that the person is no longer disabled.
- (5) **Termination provisions of this Summary Plan Description.** The person's coverage is subject to termination under the "TERMINATION" section of this Summary Plan Description.
- (6) **Enrollment under Medicare.** The person receiving continuation coverage becomes entitled to and covered under Medicare Part A or B coverage. A person will not be subject to earlier termination of continuation coverage on account of coverage under Medicare that existed prior to that person's first day of continuation coverage.

3. Election of Continuation Coverage

- a. You have 60 days to elect continuation of group coverage. The 60-day period begins on the date your group coverage would otherwise terminate due to a qualifying event or the date on which written notice of your right of continued group coverage is mailed, whichever is later.

- b. If you wish to continue group coverage as shown above, you must apply in writing to your Employer (not the Plan Manager). You must also pay your first monthly payment within 45 days of the date you elected to continue group coverage. Thereafter, your monthly payments are due and payable at the beginning of each month for which coverage is to be continued.
- c. You or your Covered Dependents must notify the Plan Sponsor within 60 days, when divorce, legal separation, a change in status resulting in a loss of eligibility as a dependent would end coverage or a second qualifying event occurs. The 60 day period begins on the date of the divorce, legal separation, change in dependent status or second qualifying event.

4. Procedures for Providing Notices Required Under This Continuation of Group Coverage Section

- a. You must comply with the time limits for providing notices required in paragraph 3 (c) above.
- b. Your notice must be in writing and contain at least the following information:
 - The names of the Covered Employee and Covered Dependents;
 - the qualifying event or disability; and
 - the date on which the qualifying event (if any) occurred.
- c. Your notice must be sent to:

Eden Prairie Independent School #272
 8100 School Road
 Eden Prairie, MN 55344-2292

The Plan will comply with applicable federal law for a Covered Employee that is called to active military duty in the uniformed services.

DISABLED EMPLOYEE

The Plan Sponsor and the Plan agree not to terminate, suspend or otherwise restrict the participation in, or the receipt of, benefits otherwise payable hereunder, to any Covered Employee who becomes totally disabled while employed by the Employer and covered hereunder while the Plan is in force, solely due to absence caused by such total disability. The Plan Sponsor may require the Covered Employee to pay all or some part of the payment for coverage in this instance. Such payment shall be made to the Plan Sponsor by that Covered Employee.

For the purpose of this section the term “total disability” means (1) the inability of an injured or ill Covered Employee to engage in or perform the duties of the Covered Employee's regular occupation or employment within the first two years of such disability and (2) after the first two years of such disability, the inability of the Covered Employee to engage in any paid employment or work for which the Covered Employee may, by education or training, including rehabilitative training, be or reasonably become qualified.

REPLACEMENT OF COVERAGE AND CONFINED COVERED PERSONS

When the Plan Sponsor replaces the Plan with that of another medical plan offering similar benefits, coverage will be extended for a Covered Person who is confined in an institution for medical care or treatment that would otherwise be covered under the Plan. Coverage will be extended only for services related to the confinement and incurred prior to the date that coverage ends or for services billed with the facility charges. Coverage for these services will end on the earlier of the date of discharge or the date benefits provided under the Plan are exhausted.

PUBLIC EMPLOYEES

Certain retired employees of public or governmental entities and their dependents may be eligible for continued coverage upon retirement, pursuant to Minnesota Statute 471.61. If you qualify under this law, you may be required to pay the entire premium for continued coverage and will be required to notify your Employer within certain deadlines, of your intent to continue coverage.

CLAIMS PROCEDURES

PROCEDURES FOR REIMBURSEMENT OF NETWORK SERVICES

When you present your identification card at the time of requesting network services from providers, paperwork and submission of claims relating to services will be handled for you by your provider. You may be asked by your provider to sign a form allowing your provider to submit the claim on your behalf. If you receive an invoice or bill from your provider for services, other than coinsurance, copayments or deductible amounts, simply return the bill or invoice to your provider, noting your enrollment in the Plan. Your provider will then submit the claim under the Plan. Your claim will be processed for payment according to the Employer's coverage guidelines.

PROCEDURES FOR REIMBURSEMENT OF SERVICES

Proof of Loss. Claims for services must be submitted to the Plan Manager at the address shown below. You must submit an itemized bill, which documents the date and type of service, provider name and charges, for the services incurred. Claims for services must be submitted within 90 days after the date services were first received for the injury or illness upon which the claim is based. Failure to file a claim within this period of time shall not invalidate nor reduce any claim if it was not reasonably possible to file the claim within that time. However, such claim must be filed as soon as reasonably possible and in no event, except in the absence of your legal capacity, later than 15 months from the date services were first received for the injury or illness upon which the claim is based. If the Plan is discontinued or if HPAI ceases to act as the Plan Manager, the deadline for claim submission is 365 days. The Plan Manager may request that additional information be submitted, as needed, to make a claim determination.

Send itemized bills to:

Claims Department
HealthPartners
P.O. Box 1289
Minneapolis, MN 55440-1289

Time of Payment of Claims. Benefits will be paid under the Plan within a reasonable time period.

Payment of Claims. Payment will be made according to the Plan Sponsor's coverage guidelines. All or any portion of any benefits for non-network services provided under the Plan on account of hospital, nursing, medical, or surgical services may, at the Plan Manager's option and, unless you request otherwise in writing not later than the time of filing the claim, be paid directly to the Non-Network Provider rendering the services. Payment for Covered Services may be offset to recover overpayments made to Network Providers.

Clerical Error. If a clerical error or other mistake occurs, that error does not deprive you of coverage for which you are otherwise eligible nor does it give you coverage under the Plan for which you are not eligible. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverage. Determination of your coverage will be made at the time the claim is reviewed. It is your responsibility to confirm the accuracy of statements made by the Plan Sponsor or the Plan Manager, in accordance with the terms of this SPD and other Plan documents.

TIME OF NOTIFICATION TO CLAIMANT OF CLAIMS

The only claims under your Plan that meet the definition of "pre-service," are those that require pre-certification by CareCheck[®]. For purposes of this claim and appeal process, all other claims, including requests for prior authorization, are considered "post-service" claims.

Pre-Service Claims (pre-certification requests).

When a request to CareCheck[®] for pre-certification for a non-urgent service is requested, an initial determination must be made within 15 calendar days. This time period may be extended for an additional 15 calendar days, provided that the Plan Manager determines that such extension is necessary due to matters beyond the control of the Plan. If such extension is necessary, you will be notified prior to the expiration of the initial 15-day period.

When a request to CareCheck[®] for pre-certification for an urgent service is requested, an initial determination must be made within 72 hours, so long as all information reasonably needed to make a decision has been provided. In the event that the claimant has not provided all information necessary to make a decision, the claimant will be notified of such failure within 24 hours. The claimant will then be given 48 hours to provide the requested information. The claimant will be notified of the benefit determination within 48 hours after the earlier of receipt of the complete information or the end of the time granted to the claimant to provide the specified additional information.

Post-Service Claims.

An initial determination of a claim for benefits must be made by HealthPartners within 30 days. This time period may be extended for an additional 15 days, provided that the Plan Manager determines that such an extension is necessary due to matters beyond the control of the Plan. If such extension is necessary, you will be notified prior to the expiration of the initial 30-day period.

You will receive written notification of any initial adverse claim determination as provided by applicable law.

CLAIM DENIALS AND CLAIM APPEALS PROCESS FOR PRE-SERVICE CLAIMS

If your request to CareCheck[®] for pre-certification is wholly or partially denied, you are entitled to appeal that decision. Your Plan provides for two levels of appeal to the named fiduciary of your Plan or its delegate. You may also have the right to an external review as described below. You must exhaust the first and second levels of the appeal process prior to bringing a civil action. The steps in this appeal process are outlined below.

First Level of Appeal. You or your authorized representative must file your appeal within 180 days of the adverse decision. Send your written request for review, including comments, documents, records and other information relating to the claim, the reasons you believe you are entitled to benefits, and any supporting documents to:

Member Services Department
HealthPartners
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

The Plan Manager will review your appeal and will notify you of its decision in accordance with the following timelines:

- If the claim being appealed is for urgent services, you or your health care provider may request an expedited appeal either orally or in writing. Within 72 hours of such request, a decision on your appeal will be made.
- If the claim being appealed is for non-urgent services, a decision on your appeal will be made within 15 days.

The time periods may be extended if you agree.

Concurrent Care Appeal. If you are appealing a reduction or termination of an ongoing course of treatment that has been previously approved by HealthPartners, you will have continued coverage under the Plan, pending the outcome of the appeal. This does not apply to requests for an extension to the already approved period of treatment or number of visits.

All notifications described above will comply with applicable law.

Second Level of Appeal. If after the first level of appeal your request was denied, you or your authorized representative may, within 180 days of the denial, submit a written appeal for review, including any relevant documents, to the Plan Manager and submit issues, comments and additional information as appropriate to:

Member Services Department
HealthPartners
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

- If the claim being appealed is for urgent services, you or your health care provider may request an expedited appeal either orally or in writing. Within 72 hours of such request, a decision on your appeal will be made.
- If the claim being appealed is for non-urgent services, a decision on your appeal will be made within 15 days.

The time periods may be extended if you agree.

All notifications described above will comply with applicable law.

CLAIM DENIALS AND CLAIM APPEALS PROCESS FOR POST-SERVICE CLAIMS (all claims except requests from CareCheck[®] for pre-certification)

If your post-service claim for benefits under the Plan is wholly or partially denied, you are entitled to appeal that decision. Your Plan provides for two levels of appeal to the named fiduciary of your Plan or its delegate. You may also have the right to an external review as described below. You must exhaust the first and second levels of the appeal process prior to bringing a civil action. The steps in this appeal process are outlined below.

First Level of Appeal. You or your authorized representative must file your appeal within 180 days of the adverse decision. Send your written request for review, including comments, documents, records and other information relating to the claim, the reasons you believe you are entitled to benefits, and any supporting documents to:

Member Services Department
HealthPartners
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

The Plan Manager will review your appeal and will notify you of its decision within 30 days.

The time period may be extended if you agree.

Concurrent Care Appeal. If you are appealing a reduction or termination of an ongoing course of treatment that has been previously approved by HealthPartners, you will have continued coverage under the Plan, pending the outcome of the appeal. This does not apply to requests for an extension to the already approved period of treatment or number of visits.

All notifications described above will comply with applicable law.

Second Level of Appeal. If after the first level of appeal, your request was denied, you or your authorized representative may, within 180 days of the denial, submit a written appeal for review, including any relevant documents, to the Plan Manager and submit issues, comments and additional information as appropriate to:

Member Services Department
HealthPartners
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

The Plan Manager will review your appeal and will notify you of its decision within 30 days.

The time periods may be extended if you agree.

All notifications described above will comply with applicable law.

EXTERNAL REVIEW PROCEDURES

You or your authorized representative must request an external review within four months of the adverse decision. If your claim is denied because of an adverse benefit determination based on judgment of medical appropriateness, you have the right to request an external review, as described below.

You also have the right to request an external review for a rescission of coverage. A rescission is a discontinuance or cancellation of coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission if it is effective retroactively because of a failure to pay premiums or contributions on a timely basis.

- If you have an adverse benefit determination that is eligible for external review, you have the right to request external review.
- To initiate the external review process, you may submit a written request for an external review to the Plan Manager. A fee may be required.
- Upon receipt of the request for external review, the Independent Review Organization must provide immediate notice of the review to the complainant and to the Plan Manager. Within 10 business days, the Covered Person and the Plan Manager must provide the reviewer with any information they wish to be considered. The Covered Person (who may be assisted or represented by a person of their choice) and the Plan Manager shall be given an opportunity to present their versions of the facts and arguments. Any aspect of the external review involving medical determinations must be performed by a health care professional with expertise in the medical issue being reviewed.
- An external review decision must be made as soon as possible, but no later than 45 days after receipt of the request for external review. The decision is binding on the Plan and the Covered Person. Prompt written notice of the decision and the reasons for it must be sent to the Covered Person and to the Plan Manager.

RESPONSIBILITIES OF COVERED PERSONS

- Read this SPD and the enrollment materials completely and comply with the stated rules and limitations.
- Contact providers to arrange for necessary medical appointments.
- Pay any applicable copayments, deductibles and contributions as stated in this SPD.
- Identify yourself as a Covered Person by presenting your identification card whenever you receive Covered Services under the Plan.

RIGHTS UPON TERMINATION OR AMENDMENT OF THE PLAN

For a summary of Plan provisions governing benefits, rights and obligations of participants and beneficiaries under the Plan on termination of the Plan or amendment or elimination of benefit under the Plan, please consult your Employer.

SPECIFIC INFORMATION ABOUT THE PLAN

Employer:	Eden Prairie Independent School #272
Name of the Plan:	The Plan shall be known as the Eden Prairie Independent School #272 Medical Benefit Plan which provides employee and dependent medical benefits.
Address of the Plan:	8100 School Road Eden Prairie, MN 55344-2292 952-975-7035
Group Number:	3119
Plan Year:	The period beginning on each July 1 in which the provisions of the Plan are in effect.
Plan Fiscal Year Ends:	December 31
Plan Sponsor: (is ultimately responsible for the management of the Plan; may employ or contract with persons or firms to perform day-to-day functions such as processing claims and performing other Plan-connected services.)	Eden Prairie Independent School #272
Agent for Service of Legal Process:	General Counsel for Eden Prairie Independent School #272
Named Fiduciary: (has the authority to control and manage the operation and administration of the Plan; has discretionary authority to determine eligibility for benefits or to construe the terms of the Plan.)	For purposes of determining eligibility and enrollment, and for funding claims paid and all related activities and responsibilities under the Plan, Eden Prairie Independent School #272 is the named fiduciary. Solely for purposes of determining coverage of claims, HealthPartners Administrators, Inc. is the named fiduciary.
Funding:	Claims under the Plan are paid from the general funds of the Employer.
Plan Manager: (provides administrative services to the Plan Sponsor in connection with the operation of the Plan, such as processing of claims and other functions, as may be delegated to it.)	HealthPartners Administrators, Inc. 8170 33 rd Avenue South P.O. Box 1309 Minneapolis, MN 55440-1309 952-883-6000
Network Providers:	Open Access Network
Contributions:	Please refer to the most recent enrollment material for information regarding contributions to your Plan which is hereby incorporated by this reference.