HealthPartners®

# Summary Plan Description

## Richfield Public Schools ISD 280 Medical Benefit Plan
## $2,700 Deductible Plan
## July 1, 2025

This Summary Plan Description (SPD), along with any amendments and the Coverage Criteria Policies, is your description of the Employer's Medical Benefit Plan. The SPD describes the Plan's benefits and limitations. Network Providers are available to view free of charge by signing in to your online account at healthpartners.com or by calling Member Services.

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**HEALTHPARTNERS MISSION**

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 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 their employment at any time.

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## INTRODUCTION TO THE SUMMARY PLAN DESCRIPTION

### SUMMARY PLAN DESCRIPTION (SPD)

**This Summary Plan Description (this SPD) effective date is the later of July 1, 2025 and the Covered Person's effective date of coverage under the Plan.**

This SPD, along with HealthPartners Coverage Criteria Policies, is your description of the Employer's Medical Benefit Plan (the Plan and/or this Plan). This 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. HealthPartners will determine eligibility for some services based on the terms of this SPD and Coverage Criteria Policies, which are subject to periodic review and modification. You may access the Coverage Criteria Policies by signing in to your online 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. Certain capitalized words used in this SPD have special meanings and are specifically defined in the SPD. The use of any gender-specific terms refer to sex assigned at birth. 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.

### 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, Bloomington, MN 55425.

### 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.

### ASSIGNMENT OF BENEFITS

Except as provided in this section, you may not, in any way, assign or transfer your rights or benefits under this SPD. In addition, you may not, in any way, assign or transfer your right to pursue any causes of action arising under this SPD including, but not limited to, causes of action for denial of benefits under this SPD.

You may assign the right to receive reimbursement for medical care and services you received under the SPD to the Provider of the medical care and services. You can revoke this assignment at any time. This assignment of benefits is available only for the right to receive reimbursement for covered medical care or services, and no other rights, responsibilities, or obligations under this SPD may be assigned to a Provider.

### HOW TO USE THE NETWORK

This SPD describes your Covered Services and how to obtain them. **The Plan provides Network Benefits and Out-of-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.

**Network Provider.** This is any one of the participating licensed Physicians, Dentists, mental health, substance use disorder or other Health Care Providers, Facilities and pharmacies, who have entered into an agreement to provide Health Care Services to Covered Persons.

**Network Providers are available to view free of charge by signing in to your online account at healthpartners.com. If you need assistance locating a Physician or other Health Care Provider in your Network, please contact Member Services.**

**Out-of-Network Providers.** These are licensed Physicians, Dentists, mental health, substance use disorder 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.** These are the Health Care Providers, Facilities and pharmacies contracted to provide services for this Plan.

**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 sign in to your online account at healthpartners.com for a current list.

In order to receive Network Benefits, the following services require using a Designated Physician, Provider, Facility or Vendor:

- You must use a designated convenience clinic to obtain the convenience clinic benefit in the Benefits Chart
- Durable Medical Equipment, prostheses, orthoses and supplies must be obtained from or repaired by approved vendors
- All services for the purpose of weight loss must be provided by a Designated Physician

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

**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 Out-of-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 under state or federal laws.

The following conditions qualify for this benefit:

- An acute condition
- A life-threatening mental or physical Illness
- Pregnancy for which you have begun care
- 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
- 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 there is not a Network 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.

Continuity of care benefits will not be available or may be discontinued if the Provider is terminated from the Network for misconduct.

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

## OUT-OF-NETWORK PROVIDER BALANCE BILLING PROHIBITION

1. Except as provided in subsection 2. below, balance billing is prohibited when you receive services from:

   (a) an Out-of-Network Provider at a Network Hospital or ambulatory surgical center, as described by the No Surprises Act, including any federal regulations adopted under that act
   (b) a Network Provider that sends a specimen taken in the Network Provider's practice setting to an Out-of-Network laboratory, pathologist, or other medical testing Facility
   (c) an Out-of-Network Provider or Facility providing Emergency Services as defined in section 62Q.55, subdivision 3, and other services as described in the requirements of the No Surprises Act

   Your financial responsibility for the Out-of-Network Provider services described above shall be the same cost-sharing requirements, including Copayments, Deductibles, Coinsurance, coverage restrictions, and coverage limitations, as those applicable to services received from a Network Provider. The Plan must apply any cost-sharing requirements, including Copayments, Deductibles and Coinsurance, for Out-of-Network Provider services to your annual Out-of-Pocket Limit to the same extent payments to a Network Provider would be applied.

   The Plan must attempt to negotiate the reimbursement, less any applicable cost sharing under subsection 1. above, for the Out-of-Network Provider services with the Out-of-Network Provider. If the attempt to negotiate reimbursement for the Out-of-Network Provider services does not result in a resolution, either party may initiate the federal independent dispute resolution process pursuant to the No Surprises Act, including any federal regulations adopted under that act.

2. The services described above in subsection 1., clauses (a), (b), and (c), as defined in the No Surprises Act, and any federal regulations adopted under that act, are subject to balance billing if you provide informed consent prior to receiving services from the Out-of-Network Provider acknowledging that the use of a Provider, or the services to be rendered, may result in costs not covered by the Plan. The informed consent must comply with all requirements of the No Surprises Act, including any federal regulations adopted under that act.

### Prior Authorization for services

Your Physician may be required to obtain Prior Authorization for certain services, including Providers who specialize in obstetrics and gynecology, as specified in Minnesota Statute 62Q.52. Your Physician will coordinate the Prior Authorization process for any services which must first be Prior Authorized. You may call the Member Services Department or sign in to your online 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 Coverage Criteria Policies, which are subject to periodic review and modification.

There is no referral requirement for services delivered by Providers within your Network.

**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 signing in to your online 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.

## ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

### ELIGIBILITY

All employees, as determined by the Plan Sponsor, working 15 hours per week (actively at work) are eligible to enroll in the Plan. 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.

### EFFECTIVE DATE OF COVERAGE

The employee's and any dependent's effective date are as follows:

Management Team and Classified Management Team Groups will be effective the first day of the month following or coinciding with the date of hire.

Administration, Teachers, RN's and Security Officers will be effective the first day of the month following the date of hire.

Custodial Staff, Food Service, Office Personnel, Paraprofessionals, and Outreach Workers will be effective the first day of the month following 30 days of employment.

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 their 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
- 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
- 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
- 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) are covered immediately from the moment of birth regardless of when notice is received by the Plan. Newly adopted Children are covered on the date of placement 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. 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., 3., 4. and 6., 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

### UNDERSTANDING YOUR COVERAGE

This Benefits Chart is the part of the SPD that explains how much you will pay for Medically Necessary services. Covered Services are based on the conditions, limitations and exclusions in this Benefits Chart, other sections of the SPD and the Coverage Criteria Policies. Coverage for Prescription Drugs which are administered in a clinic or Hospital setting are also based on your Drug Formulary.

The Coverage Criteria Policies list specific criteria that must be met for certain supplies, Health Care Services, behavioral health services, Outpatient professionally administered injections and procedures to be considered Medically Necessary. A Formulary is a list of Drugs and how they are covered. Both Coverage Criteria Policies and the Formulary contain information about Prior Authorization requirements. Your Network Provider will facilitate the Prior Authorization process for you when needed.

HealthPartners will determine eligibility for some services based on the terms of this SPD and Coverage Criteria Policies, which are subject to periodic review and modification. To learn more about Coverage Criteria Policies or your Formulary, sign in to your online account at healthpartners.com or call Member Services.

### HOW TO USE THIS BENEFITS CHART

This Benefits Chart is divided into sections based on different types of care or services. Each section includes the amount or percentage the Plan pays for Covered Services when received from Network and Out-of-Network Providers. When needed, sections will also include specific limitations or conditions for that coverage. You are responsible for the specified Copayment amount and/or percentage of Charges that the Plan does not pay. You are also responsible for all Charges related to any non-Covered Services. Please refer to any “Not Covered” lists in each benefit category as well as the “Services Not Covered” section to better understand your coverage.

Certain capitalized words have special meanings and are defined in the “Benefits Chart Definitions”, “General Definitions” or within applicable benefit categories.

### HOW YOUR CHOICE OF PROVIDERS AFFECTS YOUR COVERAGE

Your Plan’s payment for Covered Services may vary depending on whether you select a Network Provider or an Out-of-Network Provider.

For most non-Emergency Services, your benefits could be greatly reduced when you use Out-of-Network Providers. This means you will have to pay more in Out-of-Pocket Expenses. Most Out-of-Network Providers do not have a contract with HealthPartners to provide services at a discounted rate.

For Covered Services delivered by Out-of-Network Providers that do not have a contract with HealthPartners, the Plan will only pay up to the Usual and Customary Charge. This is explained in more detail in the Plan’s definitions of Charge and Usual and Customary Charge. The Usual and Customary Charge can be significantly lower than an Out-of-Network Provider's billed Charges. If the Out-of-Network Provider’s billed Charges are over the Usual and Customary Charge, you pay the difference. You also pay any required Deductible, Copayment and/or Coinsurance. Charges above the Usual and Customary Charge do not apply to your Deductible or Out-of-Pocket Limit.

The No Surprises Act prohibits “Surprise” Billing (also known as “balance” billing) in most circumstances. For the following services, your benefits are not reduced when you use Out-of-Network Providers: air ambulance, emergency care, certain post-stabilization care and certain non-Emergency Services from Out-of-Network Providers at certain Network Facilities. Provisions of the No Surprises Act do not apply to Out-of-Network claims from Providers that are outside of the US or US territories. Coverage level for services received outside of these areas is the same as corresponding Out-of-Network Benefits, depending on the type of service provided.

For questions about coverage, contact Member Services at the number on the back of your ID card.

## BENEFITS CHART DEFINITIONS

**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 or Out-of-Network Providers that have a contract with the Plan Manager, this is the Provider's contracted rate for a given service, procedure or item.

For Covered Services delivered by Out-of-Network Providers that do not have a contract with the Plan Manager, this is the Usual and Customary Charge.

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 may be liable for any charges above the Usual and Customary Charge, and they do not apply to the Deductible or Out-of-Pocket Limit.

A charge may include a cash price for a service or item.

A charge is incurred for covered Outpatient surgical and non-surgical services and for Inpatient professional and Physician fees 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 and will be covered at the benefit in place on the date of Admission for the duration of your Hospital stay.

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 an Out-of-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.

For Network Providers, the amount of the 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 Out-of-Network Providers, the amount of Charges that apply to the deductible are the lesser of the Providers' Charge or the Usual and Customary Charge for a service.

The Plan has an embedded deductible. This means once a Covered Person meets the individual deductible, the Plan begins paying benefits for that person. If two or more members of the family meet the family deductible, the Plan begins paying benefits for all members of the family, regardless of whether each Covered Person has met the individual deductible. However, a Covered Person may not contribute more than the individual deductible toward the family deductible.

**Deductible Carryover.** Charges incurred in the last three months of the Calendar Year for which this SPD is effective, which are applied to any Deductible for this Calendar Year, are carried over and applied toward any Deductible for the following Calendar Year. The Deductible carryover amount does not apply to the Out-of-Pocket Limit for the following Calendar Year.

**Lifetime Maximum Benefit.** The specified coverage limit actually paid for services and/or Charges for a Covered Person for a given procedure or diagnosis. Payment for benefits under the Plan ceases for that Covered Person when that lifetime maximum benefit is reached. The Covered Person has to pay for any subsequent Charges.

**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 Lifetime Maximum Benefit or any visit or day limits.

Out-of-Network Benefits for transplant surgery and bariatric 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.

Out-of-Network Charges above the Usual and Customary Charge do not apply to the out-of-pocket limit. See the definition of Usual and Customary Charge in this “Benefits Chart Definitions” section).

You are responsible to keep track of the Out-of-Pocket Expenses. Contact Member Services 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.

**Usual and Customary Charge.** This is the maximum amount allowed that HealthPartners considers in the calculation of payment of Charges incurred for certain Covered Services received from Out-of-Network Providers. It is consistent with the range of reasonable fees charged by other Providers of a given service or item in the same geographic region.

The usual and customary charge is determined using one of 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.

You may be liable for any amounts above the usual and customary charge, and they do not apply to the Deductible or Out-of-Pocket Limit.

## DEDUCTIBLES AND OUT-OF-POCKET LIMITS

### Calendar Year Deductible

### Individual Calendar Year Deductible

| Network Benefits | Out-of-Network Benefits |
|---|---|
| $2,700 | $3,950 |

### Family Calendar Year Deductible

| Network Benefits | Out-of-Network Benefits |
|---|---|
| $5,400 | $7,900 |

The Deductibles under the Network Benefits and the Out-of-Network Benefits are combined.

The medical Calendar Year Out-of-Pocket Limit for Network Benefits and Out-of-Network Benefits are combined with the pharmacy Calendar Year out-of-pocket limit for Network Benefits and Out-of-Network Benefits.

The Plan has an embedded Deductible. This means once a Covered Person meets the individual Deductible, the Plan begins paying benefits for that person. If two or more members of the family meet the family Deductible, the Plan begins paying benefits for all members of the family, regardless of whether each Covered Person has met the individual Deductible. However, a Covered Person may not contribute more than the individual Deductible toward the family Deductible.

### Calendar Year Out-of-Pocket Limit

### Individual Calendar Year Out-of-Pocket Limit

| Network Benefits | Out-of-Network Benefits |
|---|---|
| $2,700 | $7,900 |

### Family Calendar Year Out-of-Pocket Limit

| Network Benefits | Out-of-Network Benefits |
|---|---|
| $5,400 | None |

The Out-of-Pocket Limits under the Network Benefits and the Out-of-Network Benefits are combined.

The medical Calendar Year Out-of-Pocket Limit for Network Benefits and Out-of-Network Benefits are combined with the pharmacy Calendar Year out-of-pocket limit for Network Benefits and Out-of-Network Benefits.

Out-of-Network Benefits for transplant surgery and bariatric 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.

Out-of-Network Charges above the Usual and Customary Charge do not apply to the Out-of-Pocket Limit. See the definition of Usual and Customary Charge in the “Benefits Chart Definitions” section.

## BENEFIT DESCRIPTIONS

The Plan provides coverage for the following services based on the conditions, limitations and exclusions in this Benefits Chart, other sections of the SPD, Coverage Criteria Policies and your Drug Formulary. Please refer to any “Limitations” and "Not Covered" lists within individual benefit categories as well as the "Services Not Covered" section to better understand the coverage available to you.

The Plan will not deny coverage for habilitative or rehabilitative benefits, including prostheses or orthoses, solely on the basis of a Covered Person’s actual or perceived disability. The Plan will not deny a prosthesis or orthosis benefit for an individual with limb loss or absence that would otherwise be covered for a nondisabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

Your Employer and HealthPartners want you to get the most out of your health plan and help you live healthier. From time to time, the Plan may provide access to additional benefits, healthy discounts and rewards to encourage engagement with health plan benefits. To learn more about programs that may be available, sign in to your HealthPartners online account.

### ACUPUNCTURE

**Covered Services:**

The Plan covers acupuncture services when Medically Necessary.

Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

### AMBULANCE AND MEDICAL TRANSPORTATION

**Covered Services:**

The Plan covers ground ambulance, fixed wing air ambulance and rotary wing air ambulance for medical emergencies.

The Plan also covers ground ambulance, fixed wing air ambulance and rotary wing air ambulance for non-emergency medical transportation if it meets the Coverage Criteria Policies.

Non-emergency fixed wing air ambulance requires Prior Authorization.

Under the No Surprises Act, Out-of-Network air ambulance Providers may not bill patients for more than their cost-sharing responsibility for the corresponding Network service.

Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

**Ambulance and medical transportation (other than medical Facility transfers related to maternity care described below)**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | 100% of the Charges incurred. Deductible does not apply. Subject to the Network Out-of-Pocket Limit.<br><br>The amount you pay for air ambulance services will be determined based on the requirements of the No Surprises Act and its implementing regulations. |

**Medical Facility transfers related to maternity care.** This includes expenses related to transferring all individuals (mother, newborn and any newborn siblings, if applicable) from one medical Facility to a different medical Facility if a Health Care Provider acting within the Provider's scope of practice recommends that either the mother or newborn be transferred to a different medical Facility.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | 100% of the Charges incurred. Deductible does not apply. Usual and Customary provision does not apply. |

**AUTISM SERVICES**

**Covered Services:**

The Plan covers the diagnosis, evaluations and multidisciplinary assessment of autism spectrum disorders. In addition to other services that may be used to treat autism spectrum disorders addressed elsewhere in this Benefits Chart, the Plan covers Medically Necessary Care 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

Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

Physical therapy, occupational therapy and speech therapy are covered under the “Physical Therapy, Occupational Therapy and Speech Therapy” section.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 80% of the Charges incurred. Deductible does not apply. | 70% of the Charges incurred, after you pay the Deductible. |

**BEHAVIORAL HEALTH SERVICES**

**Definitions:**

**Mental Health Professional.** This is a psychiatrist, psychologist, or mental health therapist licensed for independent practice, lawfully performing a mental health or substance use disorder service in accordance with governmental licensing privileges and limitations, who renders mental health or substance use disorder services to Covered Persons as covered under the Plan.

**Psychiatric Residential Treatment Facility (PRTF).** This is a Facility that provides Medically Necessary treatment to individuals age 20 and younger with complex mental health needs. Physician-directed treatment is provided seven days per week at an Inpatient level of care.

**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.

**Covered Services:**

You have rights to parity in mental health and substance use disorder treatment as required by the federal Mental Health Parity and Addiction Equity Act and Minnesota Statutes, section 62Q.47. These laws require:

- That mental health and substance use disorder services be covered on the same basis as medical services
- That cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services
- That treatment restrictions and limitations such as Prior Authorization and Medical Necessity can be no more restrictive than for similar medical services
- That if a Covered Person has concerns they can call Member Services, file a complaint with HealthPartners, or file a complaint with the Minnesota Department of Commerce

**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). Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

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 and day treatment services.** 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 used 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 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
- Psychiatric collaborative care
- Treatment for gender dysphoria

Services received via Video, E-visit or Telephone are covered under the "Telehealth/Telemedicine Services" section.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 80% of the Charges incurred. Deductible does not apply. | 70% of the Charges incurred, after you pay the Deductible. |

**Group therapy**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 90% of the Charges incurred. Deductible does not apply. | 70% of the Charges incurred, after you pay the Deductible. |

**Inpatient services, including mental health residential treatment services.** The Plan covers the following:

- 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
- Medically Necessary Inpatient services in a Psychiatric Residential Treatment Facility (PRTF)
- Medically Necessary mental health residential treatment services. This care must be Prior Authorized by HealthPartners and provided by a Hospital or Residential Behavioral Health Treatment Facility licensed by the local state or Department of Health and Human Services.

Services not covered under this benefit include halfway houses, group homes, extended care Facilities, shelter services, correctional services, detention services, transitional services, housing support programs, foster care services and wilderness and outdoor programs.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**Substance use disorder (SUD) services**

The Plan covers Medically Necessary services for assessments by a licensed alcohol and drug counselor and treatment of substance use disorders as defined in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM 5) (most recent edition). Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

**Outpatient services, including intensive Outpatient and day treatment services.** The Plan covers Medically Necessary Outpatient professional services for diagnosis and treatment of substance use disorder. Substance use disorder 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 substance use disorder include the following:

- Individual, group, family and multi-family therapy provided in an office setting
- Psychiatric collaborative care
- Opiate replacement therapy including methadone and buprenorphine treatment
- Day treatment and intensive Outpatient services in a licensed program

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 80% of the Charges incurred. Deductible does not apply. | 70% of the Charges incurred, after you pay the Deductible. |

**Inpatient services.** The Plan covers the following:

- Medically Necessary Inpatient services in a Hospital or primary residential treatment in a licensed substance use disorder treatment center. Primary residential treatment is an intensive residential treatment program of limited duration, typically 30 days or less;
- Services provided in a Hospital that is licensed by the local state and accredited by Medicare
- Detoxification services in a Hospital or community detoxification Facility if it is licensed by the local Department of Health and Human Services

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**Not Covered:**

- Court-ordered mental health treatment, except as described above
- Halfway houses, group homes, extended care Facilities, shelter services, transitional services, housing support programs, foster care services, housing stabilization and low intensity residential treatment for substance use disorders
- Correctional services and detention services
- Wilderness and outdoor programs even when the program is through a licensed Facility
- Animal therapy, including hippotherapy and equine therapy
- Religious counseling
- Marital/relationship counseling
- Sex therapy
- Professional services associated with substance use disorder interventions. A "substance use disorder intervention" is a gathering of family and/or friends to encourage a Covered Person to seek substance use disorder treatment.

## CHIROPRACTIC SERVICES

**Covered Services:**

The Plan covers chiropractic services for Rehabilitative Care, provided to diagnose and treat neuromusculoskeletal conditions.

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

Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible.<br>Limited to 20 visits per Calendar Year. |

**Not Covered:**

- Massage therapy, except as described above
- Care that is not Rehabilitative in nature and Medically Necessary for the diagnosis and/or treatment of neuromusculoskeletal conditions

## CLINICAL TRIALS

**Covered Services:**

The Plan covers certain routine services if you participate in a Phase I, II, III or 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.

Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 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 Out-of-Network Benefits depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services. |

**Not Covered:**

- The Investigative item, device or service itself
- 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
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

## DENTAL SERVICES

**Covered Services:**

Dental services are limited to those specifically described in this section. Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

**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. Dentally necessary care is limited to diagnostic testing, treatment and the use of dental equipment and appliances which in the judgement of a Dentist is required to prevent deterioration of dental health, or restore dental function. Your general health must permit the necessary procedure(s). Coverage is for damage caused by external trauma to face and mouth only, not for cracked or broken teeth which result from biting, chewing, clenching or grinding of teeth.

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 a dental implant is pursued, reimbursement for the implant and any associated procedures (including bone grafting, implant placement and restoration) is limited to the amount that would be paid toward the fabrication of a removable dental prosthesis.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% 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, including anesthesia. 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.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**Medically Necessary hospitalization and anesthesia for dental care.** The Plan covers Facility-related Charges and anesthesia expenses associated with dental care completed in a Hospital, Outpatient Hospital or ambulatory surgery center for:

- Children age 4 or younger
- Pediatric dental patients when care in dental offices has been attempted unsuccessfully and usual methods of behavior modification have not been successful or when extensive amounts of restorative care, exceeding four appointments, are required
- Covered Persons who are severely psychologically impaired or developmentally disabled, regardless of age
- Covered Persons who have a serious underlying medical condition, regardless of age, for whom dental treatment would create significant or undue medical risk if not completed in a Hospital or ambulatory surgery center
- Extensive procedures which prevent an oral surgeon from providing general anesthesia in the office, regardless of age

Anesthesia is covered in a Hospital, ambulatory surgery center or a dental office. 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.

The requirement of a Hospital setting must be due to a Covered Person's underlying medical condition. Coverage is limited to Facility and anesthesia Charges. Oral surgeon/Dentist professional fees are not covered.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**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.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**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.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**Additional oral surgery**. The Plan also covers oral surgery and anesthesia for:

- Removal of partially or completely unerupted impacted teeth
- Removal of the tooth root without the extraction of the entire tooth (excluding root canal therapy)
- Gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

There is no coverage of oral surgery or associated anesthesia for the gums and tissues of the mouth when performed in connection with the extraction or repair of teeth. This includes, but is not limited to, dental restoration, reconstruction or rehabilitation to correct defects such as missing teeth, missing parts of teeth or missing soft or hard structures of the jaw and palate (examples include, but are not limited to, crowns, bridges, veneers, or any services associated with surgically placed dental implants, including, but not limited to, bone grafting or sinus lifts).

| **Network Benefits** | **Out-of-Network Benefits** |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**Orthognathic surgery.** 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.

| **Network Benefits** | **Out-of-Network Benefits** |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**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 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 Coinsurance, conditions and limitations as Durable Medical Equipment.

| **Network Benefits** | **Out-of-Network Benefits** |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**Treatment of temporomandibular disorder (TMD) and craniomandibular disorder (CMD).** The Plan covers diagnostic procedures, surgical treatment and non-surgical treatment for TMD and CMD. Services must be Medically Necessary and administered or prescribed by a Physician or Dentist. Dental services which are not required to directly treat TMD or CMD are not covered.

| **Network Benefits** | **Out-of-Network Benefits** |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**Not Covered:**

- Dental treatment, procedures or services not described above
- Accident-related dental services when any of the following is true about your treatment:
  - Provided to teeth which are not: sound, natural and unrestored
  - Initiated beyond six months from the date of the Injury

- Received beyond the initial treatment or restoration
- Received beyond 24 months from the date of Injury

- For accident-related dental services, the cost of dental implants and any associated procedures (including bone grafting, implant placement and restoration) in excess of the amount that would be paid toward the fabrication of a removable dental prosthesis
- Oral surgery and associated anesthesia for the gums and tissues of the mouth when performed in connection with the extraction or repair of teeth. This includes, but is not limited to, dental restoration, reconstruction or rehabilitation to correct defects such as missing teeth, missing parts of teeth or missing soft or hard structures of the jaw and palate (examples include, but are not limited to, crowns, bridges, veneers, or any services associated with surgically placed dental implants, including, but not limited to, bone grafting or sinus lifts).

**DIABETIC EQUIPMENT AND SUPPLIES**

**Covered Services:**

The Plan covers Physician-prescribed, medically appropriate and necessary supplies used in the management and treatment of diabetes for Covered Persons with gestational, type I or type II diabetes including durable diabetic equipment, as described below. Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

In order to be covered by this Plan, eligible items must be purchased from an approved Durable Medical Equipment vendor. Items purchased from a pharmacy are administered by MaxorPlus. For more information regarding your pharmacy benefit administrator, please contact your Employer.

**Pumps and pump supplies.** These include diabetic insulin pumps, diabetic infusion pumps and infusion pump supplies such as infusion sets, tubing, connectors and syringe reservoirs.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, if purchased from an approved vendor. Deductible does not apply.<br><br>In accordance with Minnesota Statute 62Q.481, your combined cost for medical supplies used to treat diabetes, asthma, or allergies that require the use of epinephrine auto-injectors will not exceed $50 per month, regardless of whether received through a pharmacy or a non-pharmacy Network Provider. Deductible does not apply. | 70% of the Charges incurred, after you pay the Deductible. |

**Limitations:**

- Diabetic supplies and equipment are limited to certain models and brands. The HealthPartners Commercial Diabetic Drug List includes information on required models and brands.
- Durable Medical Equipment and supplies must be obtained from or repaired by approved vendors
- The Plan requires that certain diabetic supplies and equipment be purchased at a pharmacy and, therefore, are not covered under this Plan

**Not Covered:**

- Diabetic supplies purchased at a pharmacy
- Continuous glucose monitoring systems available for purchase from a pharmacy
- Disposable diabetic supplies including needles, lancets and test strips
- Replacement or repair of any covered items, if the items are damaged or destroyed by misuse, abuse or carelessness, lost or 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
- Batteries for monitors and equipment
- Sales tax, mailing, delivery charges and service call charges

## DIAGNOSTIC IMAGING SERVICES

**Covered Services:**

This benefit applies to diagnostic imaging when ordered by a Provider and received in a clinic or Outpatient Hospital Facility.

Diagnostic imaging services received during an Inpatient Hospital or Skilled Nursing Facility stay are covered under the "Hospital and Skilled Nursing Facility Services" section.

**Associated with covered preventive services (MRI/CT procedures are not considered preventive)**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | Diagnostic imaging services associated with preventive services are covered at the benefit level shown in the "Preventive Services" section. |

**Services for Illness or Injury**

**Outpatient magnetic resonance imaging (MRI) and computed tomography (CT)**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | 70% of the Charges incurred, after you pay the Deductible. |

**All other Outpatient diagnostic imaging services**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | 70% of the Charges incurred, after you pay the Deductible. |

## DURABLE MEDICAL EQUIPMENT, PROSTHESES, ORTHOSES AND SUPPLIES

**Definitions:**

**Durable Medical Equipment (DME).** An item is considered durable medical equipment and may be covered if all of the following apply:

- Prescribed by a Health Care Provider
- Can withstand repeated use
- Is primarily and customarily used to serve a medical purpose
- Generally is not useful to a person in the absence of an Illness or Injury

**Covered Services:**

The Plan covers the following Medically Necessary equipment, supplies and services. Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

- Durable Medical Equipment, such as wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices, hospital beds, and related services
- Orthoses and prostheses. This coverage includes:
  - Breast prostheses, artificial limbs and artificial eyes (including polishing and adjustments) and related supplies

- Orthoses and prostheses as determined by the Covered Person's Provider to be the most appropriate model that meets the medical needs of the Covered Person for the purposes of performing physical activities including but not limited to running, biking, and swimming, and maximizing the Covered Person's limb function
  - Devices or device systems, supplies, accessories, and services that are customized to the Covered Person's needs
  - Orthoses and prostheses for showering or bathing
- Scalp hair prostheses (wigs) for hair loss resulting from a health condition, including but not limited to alopecia areata and chemotherapy, including necessary equipment and accessories. Scalp hair prostheses must be prescribed by a Provider.
- Replacement or repair of DME, prostheses or orthoses is covered to accommodate growth requirements or if needed due to a change in a medical condition which affects the fit or function of the item
- Medical supplies, including catheters, splints, surgical stockings, casts and dressings
- Enteral feedings
- Special dietary treatment for phenylketonuria (PKU) and oral amino acid based elemental formula if it is recommended by a PhysicianDiabetic insulin pumps purchased from an approved durable medical equipment vendor are covered under the "Diabetic Equipment and Supplies" section.In order to be covered by this Plan, eligible items must be purchased from an approved Durable Medical Equipment vendor. Items purchased from a pharmacy are administered by MaxorPlus. For more information regarding your pharmacy benefit administrator, please contact your Employer.

**Special dietary treatment for phenylketonuria (PKU) if it is recommended by a Physician**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**Oral amino acid based elemental formula**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**All other Durable Medical Equipment, prostheses, orthoses and supplies**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible.<br><br>In accordance with Minnesota Statute 62Q.481, your combined cost for medical supplies used to treat diabetes, asthma, or allergies that require the use of epinephrine auto-injectors will not exceed $50 per month, regardless of whether received through a pharmacy or a non-pharmacy Network Provider. Deductible does not apply. | 70% of the Charges incurred, after you pay the Deductible. |

**Limitations:**

Coverage of Durable Medical Equipment is limited by the following:

- Wigs for hair loss resulting from a health condition are limited to one per Calendar Year
- Payment will not exceed the cost of an alternate piece of equipment or service that is effective and Medically Necessary. This does not apply to hair prostheses (wigs) for hair loss resulting from a health condition and oral appliances for cleft lip and cleft palate.

- Coverage is limited to one prosthetic item unless bilateral prostheses are recommended and are Medically Necessary for both sides
- The Plan reserves the right to determine if an item will be approved for rental vs. purchase
- Durable Medical Equipment, prostheses, orthoses and supplies must be obtained from or repaired by approved vendors

**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 damaged or destroyed by misuse, abuse or carelessness, lost or stolen
- Duplicate or similar items, including replacement or repair of duplicate or similar items
- Labor and related charges for repair of prostheses and orthoses which are more than 60% of the cost of replacement by an approved vendor. Labor and related charges for repair of any other covered items which are more than the cost of replacement by an approved vendor.
- Charges for repair estimates, sales tax billed separately, mailing, delivery charges and service call charges
- Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience, recreation or safety. The exclusion for items for hygiene does not apply to orthoses and prostheses for showering or bathing as described above. The exclusion for items for recreation does not apply to appropriate orthoses and prostheses used for physical activities as determined by a Provider and described above.
- Communication aids or devices: equipment to create, replace or augment communication abilities. This includes, but is not limited to, speech processors, receivers, communication boards, computer or electronic assisted communication and synthesized speech devices with dynamic display.
- Hair prostheses (wigs) for cosmetic purposes including androgenic alopecia (pattern baldness). This does not apply to wigs for hair loss resulting from a health condition as described above.
- Eyeglasses, contact lenses and their fitting, measurement and adjustment, except as specifically described in the "Office Visits for Illness or Injury" section
- Household equipment which primarily has customary uses other than medical, including, but not limited to, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds
- Exercise equipment
- 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 the Plan determines are not eligible for coverage

## EMERGENCY AND URGENTLY NEEDED CARE SERVICES

**Covered Services:**

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

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.

If other services are performed during the visit, such as diagnostic imaging or laboratory services, additional Deductible and/or Coinsurance may apply. Diagnostic imaging services and laboratory services are covered under the "Diagnostic Imaging Services" and "Laboratory Services" sections.

Services received via Video, E-visit or Telephone are covered under the "Telehealth/Telemedicine Services" section.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 100% of the Charges incurred, after you pay the Network Deductible. Subject to the Network Out-of-Pocket Limit. Usual and Customary provision does not apply. |

**Emergency care services.** These are services to treat an Emergency Medical Condition. An Emergency Medical Condition is (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. Emergency care includes Emergency Services as defined in Division BB, Title I, Section 102 of the Consolidated Appropriations Act of 2021.

When reviewing claims for coverage of Emergency Services, the Plan's medical director will take into consideration (1) whether a reasonable layperson would believe that the circumstances required immediate medical care that could not wait until the next available clinic appointment or be treated through urgent care; (2) the time of day and day of the week the care was provided; and (3) the presenting symptoms, including but not limited to severe pain, to ensure that the decision to reimburse the emergency care is not made solely on the basis of the actual diagnosis.

Under the No Surprises Act, Out-of-Network emergency care Providers may not bill patients for more than their cost sharing responsibility for the corresponding Network service.

If Emergency Services are provided by an Out-of-Network Provider, with or without Prior Authorization, the Plan will not impose coverage restrictions or limitations that are more restrictive than apply to Emergency Services received from a Network Provider. Cost-sharing requirements that apply to Emergency Services received Out-of-Network are the same as the cost-sharing requirements that apply to services received In-Network and count toward the Network Deductible, if applicable. All coverage and Charges for Emergency Services comply with the No Surprises Act.

**Emergency care in a Hospital emergency room, including professional services of a Physician**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 100% of the amount determined under the law, after you pay the Network Deductible.<br>The amount you pay for these services will be determined based on the requirements of the No Surprises Act and its implementing regulations. |

**Post-stabilization services rendered as part of the visit during which the emergency room services were provided**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 100% of the amount determined under the law, after you pay the Network Deductible.<br><br>The amount you pay for these services will be determined based on the requirements of the No Surprises Act and its implementing regulations. |

**GENE THERAPY**

**Covered Services:**

The Plan covers Medically Necessary gene therapy treatment.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 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 Coverage Criteria Policies. Sign in to your HealthPartners online account or call Member Services for more information.

**HEALTH EDUCATION**

**Covered Services:**

The Plan covers education for preventive services and education for the management of chronic health problems (such as diabetes). Coverage includes diabetes Outpatient self-management training and education including medical nutrition therapy that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association for persons with gestational, type I or type II diabetes.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | 70% of the Charges incurred, after you pay the Deductible. |

**HEARING AIDS**

**Covered Services:**

The Plan covers external basic hearing aid devices (including osseointegrated or bone anchored) prescribed by a Provider or by a licensed audiologist for the correction of a hearing impairment.

Osseointegrated or bone-anchored hearing aids are only covered when hearing loss is not correctable by other covered procedures or devices.

Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

| **Network Benefits** | **Out-of-Network Benefits** |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**Limitations:**

- Coverage is limited to one basic, standard hearing aid for each ear every three years. The three-year limitation is calculated from the date the last hearing aid was purchased for a specific ear. Exceptions to this limitation will be considered based on Medical Necessity, including if the Covered Person has outgrown the hearing aid; the Covered Person's hearing has changed; or the hearing aid is no longer functional.
- 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.
- If another type of hearing aid appliance is prescribed, the current cost for a basic, standard hearing aid appliance shall be the amount which is covered toward the cost of such other appliance

**Not Covered:**

- Charges for upgrades above the cost of a basic, standard hearing aid
- Replacement hearing aid batteries or ear molds
- Duplicate hearing aids
- Replacement hearing aids for items that can be repaired to a functional level or have been lost, stolen or damaged or destroyed by misuse, abuse or carelessness
- Assistive listening devices, frequency modulation (FM) or digital modulation (DM) Systems

**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, 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 the Durable Medical Equipment benefit.

You do not need to be homebound to receive total parenteral nutrition/intravenous (TPN/IV) therapy or routine postnatal visits.

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 serious illness or life-limiting condition. 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 for coverage only when all of the following are met:

- Medically Necessary
- Provided as Rehabilitative Care, terminal care or maternity care
- Ordered by a Physician and included in the written home care plan

Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

**Physical therapy, occupational therapy, speech therapy, respiratory therapy, home health aide services and palliative care**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**TPN/IV therapy, skilled nursing services, non-routine prenatal/postnatal services and phototherapy**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% 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.

**Routine postnatal well child visits**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | 70% of the Charges incurred, after you pay the Deductible. |

**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**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 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 Out-of-Network Benefits, combined, counts toward the maximums shown above. The routine postnatal well child visits do not count toward the visit maximums.

**Limitations:**

- 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.

**Not Covered:**

- Home health services provided as a substitute for a primary caregiver in the home or as relief (respite) for a primary caregiver in the home
- Services provided by family members or residents in your home
- Custodial or Maintenance Care. This includes all services and medical equipment provided for such care.
- Social worker visits
- Services that occur outside of the home are not covered under this "Home Health Services" benefit
- Private duty nursing, except training for ventilator-dependent persons as described in the "Hospital and Skilled Nursing Facility Services" section

**HOME HOSPICE SERVICES**

**Definitions:**

**Appropriate Facility.** This is a nursing home, hospice residence, or other Inpatient Facility.

**Continuous Care.** This is from 2 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.

**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.

**Part-time.** This is up to two hours of service per day; more than two hours is considered Continuous Care.

**Covered Services:**

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 treatments with curative intent 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 treatments with curative intent); and (3) continue to meet the terminally ill prognosis as determined by HealthPartners medical director or their 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 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
  - 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
- Medically Necessary Inpatient services
- Other services:
  - Respite 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
  - Semi-electric hospital beds and other Durable Medical Equipment
  - Emergency and non-emergency care

| **Network Benefits** | **Out-of-Network Benefits** |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

Respite care is limited to five days per episode, and respite care and Continuous Care combined are limited to 30 days.

Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

**Not Covered:**

- Rest and respite services, except as described above
- Custodial Care related to hospice services, whether provided in the home or in a nursing home. This includes all services and medical equipment provided for such care. Custodial Care related to hospice services refers to 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.
- Any service not described above
- Services provided by family members or residents in your home
- Room and board are not covered if the Covered Person resides in a nursing home or hospice residential Facility
- Costs related to Inpatient confinement when care rendered by the Facility is Custodial
- Bereavement counseling

## HOSPITAL AND SKILLED NURSING FACILITY SERVICES

**Definitions:**

**Admission.** This is the Medically Necessary admission to an Inpatient Facility for the acute care of Illness or Injury.

**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.

**Hospital-at-Home.** This is a program that allows you to get needed Hospital-level care in your home instead of in the Hospital. A care team including doctors and nurses at the Hospital will provide care to you in your home through a combination of in-person visits, virtual (i.e., video and telephone enabled) visits, and remote monitoring technology until you no longer need Hospital-level care.

**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.

**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).

**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.

**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 health or substance use disorder.

**Covered Services:**

The Plan covers services as described below. Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

The Plan also covers Hospital-level and sub-acute level care in your home instead of in the Hospital when Medically Necessary and provided by a contracted Hospital-at-Home program.

**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.

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), 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 affirming (confirmation) surgery that meets criteria in the Coverage Criteria Policies.

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 the Newborns' and Mothers' Health Protection Act (NMHPA), 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).

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% 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.

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), blood derivatives, and other diagnostic or treatment related Outpatient services; Physician and other professional medical and surgical services rendered while an Outpatient, including gender affirming (confirmation) surgery that meets criteria in the Coverage Criteria Policies.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% 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, Occupational Therapy and Speech Therapy". To see the benefit for injections administered in an Outpatient Hospital, see the benefits under "Outpatient Professionally Administered Injections".

**Skilled Nursing Facility care.** The Plan covers Medically Necessary room and board, daily skilled nursing and related ancillary services for post-acute treatment and Rehabilitative Care of Illness or Injury. Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply**.**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |
| Limited to a 120 day maximum per Calendar Year. | Limited to a 120 day maximum per Calendar Year. |

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

**Not Covered:**

- Services or items for personal convenience such as television rental

## INFERTILITY/FERTILITY SERVICES

**Covered Services:**

The Plan covers the diagnosis of infertility. These services include diagnostic procedures and tests provided in connection with an infertility evaluation, office visits and consultations to diagnose infertility.

The Plan also covers professional fertility treatment services. These services include artificial insemination (AI), intrauterine insemination (IUI), Medically Necessary tests, Facility Charges, fertility Drugs when administered during an office visit and laboratory work related to Covered Services.

**Infertility Diagnosis**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 100% of the Charges incurred, after you pay the Network Deductible. Subject to the Network Out-of-Pocket Maximum. Usual and Customary provision does not apply. |

**Fertility treatment**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

Fertility services for Network Benefits and Out-of-Network Benefits are limited to a combined $5,000 Calendar Year maximum benefit.

**Not Covered:**

- Assisted reproduction (ART), 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
- Fertility treatment after reversal of sterilization
- Sperm, ova or embryo acquisition, retrieval or storage
- Surrogacy/gestational carrier compensation, services and fees
- Maternity services for a surrogate/gestational carrier not covered under this SPD
- See Reproductive and maternity care in “Services Not Covered”

## LABORATORY SERVICES

**Covered Services:**

This benefit applies to laboratory services when ordered by a Provider and received in a clinic or Outpatient Hospital Facility.

Biomarker testing to diagnose, treat, manage, and monitor an Illness or a disease may be covered when the test provides information that is used to make clinical decisions, such as determining a treatment or monitoring strategy that impacts a patient's outcome. Sign in to your HealthPartners online account or call Member Services to determine if Coverage Criteria Policies apply. BRCA testing for females whose family history is associated with an increased risk for BRCA1 or BRCA2 gene mutations is covered under the “Women’s preventive health Services” benefit.

Laboratory services received during an Inpatient Hospital or Skilled Nursing Facility stay are covered under the “Hospital and Skilled Nursing Facility Services” section.

**Associated with covered preventive services**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | Laboratory services associated with preventive services are covered at the benefit level shown in the "Preventive Services" section. |

**Prostate-specific antigen (PSA) testing**. The Plan covers prostate cancer screening for individuals age 40 or older who are symptomatic or in a high-risk category and for all individuals age 50 or older.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | 70% of the Charges incurred, after you pay the Deductible. |

**For Illness or Injury**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | 70% of the Charges incurred, after you pay the Deductible. |

Reimbursement for over-the-counter COVID-19 tests is available through MaxorPlus and is not eligible for reimbursement under this medical Plan. Contact MaxorPlus for more information.

**LYME DISEASE SERVICES**

**Covered Services:**

The Plan covers services for the treatment of Lyme disease. Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 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 Out-of-Network Benefits depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services. |

**MASTECTOMY RECONSTRUCTION**

**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.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 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 Out-of-Network Benefits depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services. |

## MEDICATION THERAPY DISEASE MANAGEMENT PROGRAM

**Covered Services:**

You may qualify for the Medication Therapy Disease Management Program. The program covers consultations with a designated Network pharmacist. Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | No coverage. |

## OFFICE VISITS FOR ILLNESS OR INJURY

**Covered Services:**

The Plan covers the following:

- Professional medical and surgical services and related supplies of Physicians and other Health Care Providers, including biofeedback
- Blood (unless replaced) and blood derivatives
- 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, acute or chronic corneal pathology, 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 initial physical evaluation of a Child if it is ordered by a Minnesota juvenile court

Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

If other services are performed during the visit, such as diagnostic imaging or laboratory services, additional Deductible and/or Coinsurance may apply. Diagnostic imaging services and laboratory services are covered under the "Diagnostic Imaging Services" and "Laboratory Services" sections. To see the benefit for injections administered in an office, see the benefits under "Outpatient Professionally Administered Injections".

Services received via Video, E-visit or Telephone are covered under the "Telehealth/Telemedicine Services" section.

**Office visits**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**Convenience clinics.** These are clinics that offer a limited set of services and do not require an appointment.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**Not Covered:**

- Court-ordered services, except as described above
- Eyewear options, including, but not limited to, ultraviolet absorbing properties, scratch resistant or protective coating, sunglasses in addition to other lenses, anti-reflective coating, edge treatment, fashion tints or polarized lenses, frames, contact lens cleaning solution or normal saline for contact lenses, progressive lenses or invisible bifocals, low vision aids or oversize lenses

## OUTPATIENT PROFESSIONALLY ADMINISTERED INJECTIONS

**Covered Services:**

The Plan covers injections administered in a Physician's office or Outpatient Facility, including professional administration of Drugs and blood products.

**Allergy injections**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**All other injections (other than routine preventive immunizations)**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**Limitations:**

- The Plan requires Prior Authorization for certain Drugs and the site where the Drug will be administered. Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

## PEDIATRIC NEUROPSYCHIATRIC CONDITIONS

**Definitions:**

**Pediatric Acute-onset Neuropsychiatric Syndrome (PANS):** 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 (PANDAS):** 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.

**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, behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 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 Out-of-Network Benefits depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services. |

## PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY

**Definitions:**

**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 their designee, based on objective documentation.

**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.

**Covered Services:**

The Plan covers the following physical therapy, occupational therapy and speech therapy services provided in a clinic:

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

Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

Physical therapy, occupational therapy and speech therapy received in a Hospital or Skilled Nursing Facility are covered under the “Hospital and Skilled Nursing Facility Services” section. When received in the home, these services are covered under the “Home Health Services” section.

**Rehabilitative Care**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible.<br>Physical and occupational therapy combined are limited to 20 visits per Calendar Year.<br>Speech therapy is limited to 20 visits per Calendar Year. |

**Habilitative Care**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible.<br>Physical, occupational and speech therapy, combined, are limited to 20 visits per Calendar Year. |

**Not Covered:**

- Massage therapy, except as described above
- Maintenance Care

## PORT WINE STAIN REMOVAL SERVICES

**Covered Services:**

The Plan covers port wine stain removal services.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 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 Out-of-Network Benefits depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services. |

## PRE-DIABETES DISEASE MANAGEMENT PROGRAM

**Covered Services:**

A diabetes prevention program is available through Omada Health for Covered Persons who qualify for coverage after completing an online assessment.

The Pre-Diabetes Disease Management Program offers group health coaching focusing on weight loss, exercise, behavior modification and health education.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | Not applicable. |

## PRESCRIPTION DRUGS

Another vendor administers Prescription Drug services. Prescription Drug services are administered by MaxorPlus.

For more information regarding this vendor, please contact your Employer.

Benefits for all Outpatient Prescription Drugs and other pharmacy items, including but not limited to, glucose monitors, diabetic supplies, growth hormone, blood products and blood derivatives and special dietary supplies for phenylketonuria (PKU), are administered by another vendor. The benefits described in this SPD only cover Prescription Drugs which are administered during an office visit, an emergency room or urgent care visit, an Outpatient Hospital visit or an Inpatient stay.

## PREVENTIVE SERVICES

**Definitions:**

**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, unless otherwise indicated below, standard Deductibles, Copayments or Coinsurance apply.

**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.

**Covered 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 (ACIP) of the Centers for Disease Control and Prevention (CDC) 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
- With respect to women, preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration

Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

**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.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | 70% 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 for Children age 18 or younger. The Plan covers at least 11 child health supervision visits from birth to 36 months and once a year from 36 months to 72 months.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | 70% of the Charges incurred, after you pay the Deductible. |

**Routine prenatal care and exams**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | 70% 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.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | 70% of the Charges incurred, after you pay the Deductible. |

**Routine screening procedures for cancer.** This includes colorectal screenings, digital rectal examinations or other cancer screenings recommended by the USPSTF with an A or B rating, including the associated preventive office visit Charge. "Women's Preventive Health Services" below describes additional routine screening procedures for cancer.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | 70% 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.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | 100% of the Charges incurred. Deductible does not apply. Usual and Customary provision does not apply. |

**Adult immunizations.** This includes routine preventive immunizations indicated on the Adult Immunization Schedule published by the ACIP (available at cdc.gov/vaccines/schedules). Immunizations for travel and non-routine immunizations (e.g. rabies) are covered when Medically Necessary under the "Office Visits for Illness or Injury" benefit.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | 70% of the Charges incurred, after you pay the Deductible. |

**Women's preventive health services.** This includes 2D and 3D mammograms; screenings for cervical cancer (pap smears), including the associated preventive office visit Charge; 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 and provided by a Physician, sterilization procedures, education and counseling. For females 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.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply.<br><br>If a Provider determines that additional diagnostic services or testing is required after a mammogram, the additional diagnostic services or testing will be covered at 100% of the Charges incurred. Deductible does not apply. | 70% 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.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | 70% 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**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | 70% of the Charges incurred, after you pay the Deductible. |

**Routine hearing exams**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred. Deductible does not apply. | 70% of the Charges incurred, after you pay the Deductible. |

**Ovarian cancer surveillance tests and associated office visits for individuals 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 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 FDA or by the National Cancer Institute.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| Coverage level is same as corresponding Network Benefits 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 Out-of-Network Benefits 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.

**RAPID WHOLE GENOME SEQUENCING AS REQUIRED UNDER MN STATUTE 62A.3098**

**Definitions:**

**Rapid Whole Genome Sequencing (rWGS).** This is an investigation of the entire human genome, including coding and noncoding regions and mitochondrial deoxyribonucleic acid, to identify disease-causing genetic changes that returns the final results in 14 days. Rapid whole genome sequencing includes patient-only whole genome sequencing and duo and trio whole genome sequencing of the patient and the patient's biological parent or parents.

**Covered Services:**

The Plan covers Rapid Whole Genome Sequencing when all of the following are met:

- The Covered Person is age 21 or younger
- The Covered Person has a complex or acute Illness of unknown origin that has been confirmed to not be caused by an environmental exposure, toxic ingestion, infection with a normal response to therapy or a trauma
- The Covered Person is receiving Inpatient Hospital services in an intensive care unit or a neonatal or high acuity pediatric care unit

In addition, all of the following must be true about the Covered Person's condition:

- The Covered Person has symptoms that suggest a broad differential diagnosis that would require an evaluation by multiple genetic tests if rWGS testing is not performed;
- Timely identification of a molecular diagnosis is necessary in order to guide clinical decision making, and the rWGS testing may aid in guiding the treatment or management of the Covered Person's condition; and
- The Covered Person's complex or acute Illness of unknown etiology includes at least one of the following conditions:
  - Congenital anomalies involving at least two organ systems, or complex or multiple congenital anomalies in one organ system
  - Specific organ malformations that are highly suggestive of a genetic etiology
  - Abnormal laboratory tests or abnormal chemistry profiles suggesting the presence of a genetic disease, complex metabolic disorder, or inborn error of metabolism
  - Refractory or severe hypoglycemia or hyperglycemia
  - Abnormal response to therapy related to an underlying medical condition affecting vital organs or bodily systems
  - Severe muscle weakness, rigidity, or spasticity
  - Refractory seizures
  - A high-risk stratification on evaluation for a brief resolved unexplained event with any of the following features:
    - A recurrent event without respiratory infection
    - A recurrent seizure-like event
    - A recurrent cardiopulmonary resuscitation
  - Abnormal cardiac diagnostic testing results that are suggestive of possible channelopathies, arrhythmias, cardiomyopathies, myocarditis, or structural heart disease
  - Abnormal diagnostic imaging studies that are suggestive of underlying genetic condition
  - Abnormal physiologic function studies that are suggestive of an underlying genetic etiology
  - Family genetic history related to the patient's condition

| **Network Benefits** | **Out-of-Network Benefits** |
|---|---|
| Coverage level is same as corresponding Network Benefits depending on the type of service provided, such as Laboratory Services or Inpatient Hospital services. | Coverage level is same as corresponding Out-of-Network Benefits depending on the type of service provided, such as Laboratory Services or Inpatient Hospital services. |

**RARE DISEASE DIAGNOSIS AND TREATMENT**

**Definitions:**

**Rare Disease or Condition.** This is any disease or condition that:

- Affects fewer than 200,000 persons in the United States and is chronic, serious, life-altering, or life-threatening
- Affects more than 200,000 persons in the United States and a Drug for treatment has been designated as a Drug for a rare disease or condition pursuant to United States Code, title 21, section 360bb
- Is labeled as a rare disease or condition on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health

A rare disease or condition does not include an infectious disease that has widely available and known protocols for diagnosis and treatment and that is commonly treated in a primary care setting, even if it affects less than 200,000 persons in the United States.

**Covered Services:**

The Plan provides Network Benefits for the diagnosis, monitoring and treatment of a Rare Disease or Condition, as defined above, when received from an Out-of-Network Provider.

The Plan also provides Network Benefits for the diagnosis of a presumed Rare Disease or Condition from an Out-of-Network Provider, as long as you have met all of the following criteria prior to seeking care from an Out-of-Network Provider:

- Have received two or more clinical consultations from a Primary Care Provider or Specialty Care Provider that are specific to the presenting complaint;
- Have documentation in your medical record of a developmental delay through standardized assessment, developmental regression, failure to thrive, or progressive multisystemic involvement; and
- Have had laboratory or clinical testing that failed to provide a definitive diagnosis or resulted in conflicting diagnoses

Any Prior Authorization requirements apply to services received from both Network and Out-of-Network Providers.

Network Benefits for these services from an Out-of-Network Provider will be discontinued if you are definitively diagnosed with a disease or condition that does not meet the definition of a Rare Disease or Condition. At that time, any additional services provided by, referred for, or ordered by an Out-of-Network Provider related to the diagnosis are covered at the Network Benefit for up to 60 days following the diagnosis to provide time for care to be transferred to a qualified Network Provider. After this 60-day period, subsequent services provided by, referred for, or ordered by an Out-of-Network Provider related to the diagnosis may be covered as Out-of-Network Benefits.

Call Member Services at the number on the back of your ID card if you have questions on how to obtain this coverage.

| Network Benefits | Out-of-Network Benefits |
|---|---|
| Coverage level is same as corresponding Network Benefits, depending on type of service provided, such as Office Visits for Illness or Injury. | Coverage level is same as corresponding Network Benefits, depending on type of service provided, such as Office Visits for Illness or Injury. |

Note: If HealthPartners does not have a contract with the Out-of-Network Provider, the determination of eligible Charges will be based on the Provider's established rate for uninsured patients for that service. If the Provider does not have an established rate for uninsured patients, the determination of eligible Charges will be based on the average commercial insurance rate that HealthPartners has paid for that service in the state where the service is provided over the past 12 months. If HealthPartners has not paid for that service in that state in the past 12 months, then the Charge will be based on the lesser of the average rate HealthPartners has paid for that service across all states over the past 12 months or the Provider's standard Charge. If the Provider is outside the state of Minnesota, the Provider may not consider the payment in full and could bill you for any amounts above your Copayment or Coinsurance.

## SPECIFIED OUT-OF-NETWORK SERVICES

### Covered Services:

The Plan covers the following services, when a Covered Person elects to receive them from an Out-of-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

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 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. |

**TELEHEALTH/TELEMEDICINE SERVICES**

**Definitions:**

**E-visit or Chat-Based Visits.** Asynchronous online or mobile app encounters to discuss a patient's personal health information, vital signs, and other physiologic data or diagnostic images. The Health Care Provider reviews and delivers a consultation, diagnosis, prescription or treatment plan after reviewing the patient's visit information.

**Telehealth, Telemedicine, or Virtual Care.** This is a means of communication between a health care professional and a patient. This includes the use of secure electronic information, imaging, and communication technologies, including:

- Interactive audio or audio-video
- Interactive audio with store-and-forward technology
- Chat-based and email-based systems
- Physician-to-Physician consultation
- Patient education
- Data transmission
- Data interpretation
- Digital diagnostics (algorithm-enabled diagnostic support)
- Digital therapeutics (the use of personal health devices and sensors, either alone or in combination with conventional Drug therapies, for disease prevention and management)

Services can be delivered:
Synchronously: the patient and health care professional are engaging with one another at the same time; or
Asynchronously: the patient and health care professional engage with each other at different points in time.

**Telephone Visits.** Live, synchronous, interactive encounters over the telephone between a patient and a Health Care Provider.

**Video Visits.** Live, synchronous, interactive encounters using secure web-based video between a patient and a Health Care Provider.

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

**Covered Services:**

The Plan covers the following methods of receiving care for services that would be eligible under the Plan if the service were provided in person.

**Scheduled Telephone Visits**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**Virtuwell visits through virtuwell.com**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible.<br>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 100% of the Charges incurred, after you pay the Deductible. | Not applicable. |

**E-visits**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**Video Visits**

| Network Benefits | Out-of-Network Benefits |
|---|---|
| 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 Out-of-Network Benefits depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services. |

**TRANSPLANT SERVICES**

**Definitions:**

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

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

**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.

**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).

**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 below, including all related post-surgical treatment, follow-up care 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.

**Covered Services:**

For Network Benefits, Transplant Services must be received at a Designated Transplant Center. Covered Services provided by a Network Facility that is not a Designated Transplant Center will be covered under the Out-of-Network Benefits.

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
- Cornea transplants
- Heart transplants
- Lung transplants or heart/lung transplants
- Liver transplants
- Allogeneic Bone Marrow Transplants or peripheral Stem Cell Support associated with high dose chemotherapy
- Autologous Bone Marrow Transplants or peripheral Stem Cell Support associated with high-dose chemotherapy
- Simultaneous pancreas-kidney transplants, pancreas after kidney transplant, living related segmental simultaneous pancreas kidney transplantation and pancreas transplant alone

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.

Unless the donor is a family member covered under this Plan, donors are not considered Covered Persons and are therefore not eligible for the rights afforded to Covered Persons under this Plan. Ongoing medical care and/or treatment of medical complications that may occur to the donor are not covered. When the donor is a family member covered under the same Plan, medical and Hospital expenses of the donor are covered.

Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply and to view a list of Designated Transplant Centers.

| **Network Benefits** | **Out-of-Network Benefits** |
|---|---|
| 100% of the Charges incurred, after you pay the Deductible. | 70% of the Charges incurred, after you pay the Deductible. |

**Not Covered:**

- For Network Benefits, Transplant Services provided by a Facility that is not a Designated Transplant Center. Covered Services provided by a Network Facility that is not a Designated Transplant Center will be covered under the Out-of-Network Benefits. This does not apply to coverage required by the No Surprises Act as described in this SPD or to an Out-of-Network Provider as described in the "Out-of-Network Provider Balance Billing Prohibition" section.
- Transplants not listed in Coverage Criteria Policies
- Surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, except as described above
- Non-human organ implants and/or transplants

**TRAVEL BENEFIT**

**Covered Services:**

The Plan may provide travel and lodging when a Covered Person needs a transplant or Chimeric antigen receptor T-cell (CAR-T) therapy and a Designated Transplant Center or CAR-T treatment center is greater than 100 miles from the Covered Person's primary address.

You will need to submit a Travel Benefit Claim Form and related receipts of services to receive reimbursement for eligible travel and lodging expenses. Sign in to your HealthPartners online account or call Member Services to access the Travel Benefit Claim Form or to determine if additional Coverage Criteria Policies apply.

Subject to your Network Deductibles and Out-of-Pocket Limits

| **Benefits** |
| --- |
| 100% of the Charges incurred, after you pay the Deductible.<br><br>Expenses for travel and lodging for the Covered Person (the recipient) and one adult companion may be covered up to a maximum benefit of $10,000 per transplant or CAR-T therapy.<br><br>Commercial lodging reimbursement (as may be adjusted by IRS rules) is limited to a maximum of $50 per night if the Covered Person travels alone or a maximum of $100 per night if the Covered Person travels with a companion. |

**Not Covered:**

- Travel, transportation, meals or lodging expenses, except as specified above

**WEIGHT LOSS SURGERY OR BARIATRIC SURGERY**

**Covered Services:**

For Network Benefits, all services for weight loss surgery or bariatric surgery must be received from a Designated Weight Loss Surgery Provider. Covered Services provided by a Network Facility or Physician who is not a Designated Weight Loss Surgery Provider will be covered under the Out-of-Network Benefits. If you reside outside of the region of Designated Weight Loss Surgery Providers, the Plan will work with you to find an approved Network Provider.

Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply and to obtain a current list of Designated Weight Loss Surgery Providers.

| **Network Benefits** | **Out-of-Network Benefits** |
| --- | --- |
| 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 Out-of-Network Benefits depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services. |

**Lifetime Maximum Benefit for weight loss surgery or bariatric surgery**

| **Network Benefits** | **Out-of-Network Benefits** |
| --- | --- |
| Unlimited | $5,000 |

**Not Covered:**

- For Network Benefits, all services for weight loss surgery or bariatric surgery not received from a Designated Weight Loss Surgery Provider, except as described in the "Out-of-Network Provider Balance Billing Prohibition" section. Covered Services provided by a Network Facility or Physician who is not a Designated Weight Loss Surgery Provider will be covered under the Out-of-Network Benefits. If you reside outside of the region of Designated Weight Loss Surgery Providers, the Plan will work with you to find an approved Network Provider.

See Weight loss services in "Services Not Covered"

## SERVICES NOT COVERED

This is one of several sections you need to review to understand your benefits and what you will pay when you receive care. Please also refer to any "Limitations" and "Not Covered" lists within individual benefit categories, as well as limitations and terms specified elsewhere in the SPD. Additional coverage information is available in the Coverage Criteria Policies and Formulary. Sign in to your online account at healthpartners.com or call Member Services to determine if additional requirements apply.

Unless coverage is required by law or specifically described in this SPD, the Plan will not cover any Charges for the services, treatments, items or supplies described in this section. This is true even if a Physician or Health Care Provider recommends or orders it.

Headings are used in this section to help you find exclusions. A heading does not define, change or limit an exclusion. All exclusions in this section apply to you.

**Certifications/Examinations**

Any health services, certifications or examinations required by a third party when not otherwise Medically Necessary or eligible preventive care. This includes, but is not limited to, services:

- To get or keep a job, including vocational assessments
- Required under a labor agreement or other contract
- Needed for legal proceedings. This includes, but is not limited to, services related to custody evaluations, parenting assessments, adoption studies, reports to the court, risk assessments for sexual offenses, educational classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) competency evaluations.
  - The Plan does cover the initial examination of a Child ordered by a juvenile court and court ordered behavioral health treatment as described in the "Mental Health Services" section or as otherwise required by law
  - This exclusion does not apply to substance use disorder treatment for which coverage is required by Minnesota Statute 62Q.137
- For purposes of insurance
- To get or keep a license

**Dental services**

- Dental treatment, procedures or services not described under the "Dental Services" section
- Accident-related dental services when any of the following is true about your treatment:
  - Provided to teeth which are not: sound, natural and unrestored
  - Initiated beyond six months from the date of the Injury
  - Received beyond the initial treatment or restoration
  - Received beyond 24 months from the date of Injury
- For accident-related dental services, the cost of dental implants and any associated procedures (including bone grafting, implant placement and restoration) in excess of the amount that would be paid toward the fabrication of a removable dental prosthesis

- Oral surgery and associated anesthesia for the gums and tissues of the mouth when performed in connection with the extraction or repair of teeth. This includes, but is not limited to, dental restoration, reconstruction or rehabilitation to correct defects such as missing teeth, missing parts of teeth or missing soft or hard structures of the jaw and palate (examples include, but are not limited to, crowns, bridges, veneers, or any services associated with surgically placed dental implants, including, but not limited to, bone grafting or sinus lifts).

**Hearing services**

- Communication aids or devices: equipment to create, replace or augment communication abilities. This includes, but is not limited to, speech processors, receivers, communication boards, computer or electronic assisted communication and synthesized speech devices with dynamic display.

**Investigative services**

The Plan does not cover the use of any item or service HealthPartners determines is Investigative or otherwise not Clinically Accepted, including, but not limited to, procedures, treatments, technologies, equipment, devices, Facilities and Drugs.

For more information on how HealthPartners determines when an item or service is investigational, see the definition of Investigative in the "General Definitions" section.

**Nutrition**

- Medical foods
- 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. This exclusion does not apply to special dietary treatment for phenylketonuria (PKU) if it is recommended by a Physician or oral amino acid based elemental formula or other items if they meet criteria in the Coverage Criteria Policies.

**Physical appearance**

- Surgery, services, treatments or Drugs that improve or enhance the shape or appearance of the body for purposes other than treating an Illness or Injury. These types of services are considered cosmetic and are not covered whether or not they also impact the psychological/emotional well-being or self-esteem of the Covered Person. Examples include, but are not limited to, enhancement procedures, reduction procedures and scar revision surgery. This exclusion does not apply to services for port wine stain removal, Reconstructive Surgery, gender affirming health care services and emergency care required due to complications of Cosmetic Surgery.
- Hair prostheses (wigs) for cosmetic purposes including androgenic alopecia (pattern baldness). This does not apply to wigs for hair loss resulting from a health condition as described in the "Durable Medical Equipment, Prostheses, Orthoses and Supplies" section.

**Providers/Network**

- Network Benefits for treatment, procedures or services received from Out-of-Network Providers*
- Out-of-Network billed Charges above the Usual and Customary Charge*
- For Network Benefits, Transplant Services provided by a Facility that is not a Designated Transplant Center. Covered Services provided by a Network Facility that is not a Designated Transplant Center will be covered under the Out-of-Network Benefits.*
- Services from Providers or Facilities that are not licensed
- Services outside the scope of practice or license of the individual or Facility providing the services

*These items do not apply to coverage required by the No Surprises Act as described in this SPD or to an Out-of-Network Provider as described in the "Out-of-Network Provider Balance Billing Prohibition" section.

**Reproductive and maternity care**

- Assisted reproduction (ART), 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

- Fertility treatment after reversal of sterilization
- Sperm, ova or embryo acquisition, retrieval or storage
- Surrogacy/gestational carrier compensation, services and fees
- Maternity services for a surrogate/gestational carrier not covered under this SPD
- Elective home births

**Services that are not Medically Necessary**

The Plan covers services that are appropriate in terms of type, frequency, level, setting and duration to your diagnosis or condition. Services that are outside of generally accepted practice guidelines are not covered. This includes, but is not limited to:

- Treatment, procedures, services or Drugs that do not meet the Plan's definition of Medically Necessary Care as explained in the "General Definitions" section
- Services primarily educational in nature, including, but not limited to, nonmedical self-care or self-help training. This also includes programs to help you develop academic skills (educational therapy).
- Skills training
- Services needed because of your job. This includes programs to help you prepare for, find and/or keep a job (vocational rehabilitation)
- Services related to activities you do for enjoyment. This includes recreational therapy and physical or occupational therapy to improve athletic ability. It also includes braces or guards to prevent sports injuries. This exclusion does not apply to appropriate orthoses and prostheses used for physical activities as determined by a Provider and described in the "Durable Medical Equipment, Prostheses, Orthoses and Supplies" section.
- Any service or item not used for a medical need or purpose. This includes items and services for comfort, convenience or appearance.

**Types of care**

- Services provided by naturopathic providers. Naturopathic providers are specialists in natural treatment of primary care conditions who prevent, assess and treat injuries, conditions, and diseases using complementary and alternative health care practices.
- Music therapy
- Massage therapy as a standalone treatment
- Routine foot care, unless you have one of the systemic conditions listed in the Coverage Criteria Policy. This includes metabolic, neurologic, or peripheral vascular disease that has resulted in severe circulatory compromise or areas of desensitization in the legs or feet. Call Member Services or sign in to your online account at healthpartners.com for more information.
- Rest and respite services, including all services and medical equipment provided for such care, except as described under the "Home Hospice Services" section
- Custodial Care or Maintenance Care, including all services and medical equipment provided for such care
- Services provided by family members or residents in your home
- Halfway houses, group homes, extended care Facilities, shelter services, transitional services, housing support programs, foster care services, housing stabilization and low intensity residential treatment for substance use disorders
- Correctional services and detention services
- Wilderness and outdoor programs even when the program is through a licensed Facility
- Animal therapy, including hippotherapy and equine therapy
- Foster care, adult foster care and any type of family childcare provided or arranged by the local state or county
- Court-ordered services or treatment unless coverage is described in the "Behavioral Health Services" or "Office Visits for Illness or Injury" sections
- Private duty nursing. This exclusion does not apply to training for ventilator-dependent persons as described in the "Hospital and Skilled Nursing Facility Services" section of this SPD.

**Vision services**

- Vision correction (refractive) surgeries in otherwise healthy eyes to replace eyeglasses or contact lenses. Examples include, but are not limited to, LASIK, radial keratotomy, laser and other refractive eye surgery.
- Eyeglasses, contact lenses and their fitting, measurement and adjustment, except as described in the "Office Visits for Illness or Injury" section

**Weight loss services**

- For Network Benefits, all services for weight loss surgery or bariatric surgery not received from a Designated Weight Loss Surgery Provider, except as described in the "Out-of-Network Provider Balance Billing Prohibition" section. Covered Services provided by a Network Facility or Physician who is not a Designated Weight Loss Surgery Provider will be covered under the Out-of-Network Benefits. If you reside outside of the region of Designated Weight Loss Surgery Providers, the Plan will work with you to find an approved Network Provider.
- Commercial weight loss centers, support groups and programs
- Nutritional supplements, foods and phytotherapy, including, but not limited to, vitamins, amino acid supplements and commercially prepared or pre-packaged foods
- Acupuncture for weight loss
- Biofeedback for weight loss
- Inpatient or day treatment programs for weight loss

**All other exclusions**

- All services, testing, equipment, devices, technologies and supplies purchased or available Over-the-Counter, including those recommended or managed by a Health Care Provider
- Health club memberships, exercise programs and use or purchase of exercise equipment
- Physical performance testing and measurement as part of an exercise program
- Lifestyle-behavioral resources or equipment, including, but not limited to, support groups and programs
- Services associated with non-Covered Services, including, but not limited to, treatment, procedures, diagnostic tests, monitoring, laboratory services, Drugs and supplies. This exclusion does not apply to Medically Necessary complications related to an excluded service if they would otherwise be covered under this Plan.
- Non-medical administrative costs, including, but not limited to:
  - Medical record preparation or mailing
  - Appointment cancellation fees
  - After hours appointment charges
  - Interest charges
- 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
- Sales tax
- Charges for phone, data, software or mobile applications/apps unless described as covered in the Coverage Criteria Policies for the device or service
- Treatment, procedures, services, supplies or Drugs received when you are not covered under this Plan
- 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
- Services that would not otherwise be charged if you did not have health plan coverage
- Services you have no legal obligation to pay
- Charges from Providers who waive Copayment, Deductible and Coinsurance payments by the Covered Person
- Autopsies
- Financial or legal counseling services
- Housekeeping or meal services
- Duplicate charges or charges for duplicate services
- Services or items prohibited by law in the applicable jurisdiction in which they are received

- All Prescription Drugs, medications or pharmacy items other than those administered during an office visit, during an emergency room or urgent care visit, an Outpatient Hospital visit or an Inpatient stay or unless otherwise specified in this SPD
- Nonprescription (Over-the-Counter) drugs, including, but not limited to, vitamins, supplements and homeopathic remedies
- Non-FDA approved Drugs
- Drugs used for a purpose or prescribed in a way that is not included in the labeling of FDA-approved Drugs
- Medical foods, unless listed on the Formulary and prescribed by a Physician or legally authorized Health Care Provider under applicable state and federal law and obtained from an approved Durable Medical Equipment vendor
- Medical cannabis
- 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. The Excluded Drug List is available by signing in to your HealthPartners online account.
- Drugs and indications that are newly approved by the FDA until they are reviewed and coverage is established by the HealthPartners Pharmacy and Therapeutics Committee
- Drugs that HealthPartners determines are Investigative

## GENERAL DEFINITIONS

**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 signing in to your online account at healthpartners.com.

**CareLine℠ 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.

**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 their 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 and covered by the Plan, as described in this SPD.

**Custodial Care.** These are supportive services 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.

**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. Under the Plan, a person who is considered a Covered Employee is not qualified as an eligible dependent. 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. If more than one spouse is covered as an employee under the Plan, only one spouse shall be considered to have any Eligible Dependents.
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 is financially dependent on the covered grandparent and resides with that covered grandparent continuously from birth. 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 grandchild is no longer financially dependent on the covered grandparent, no longer resides with the covered grandparent or the 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 on the Covered 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 on you for support and maintenance. Disabled dependents are not subject to any pre-existing condition limitations, or insurability, eligibility, or health underwriting approval.

**Emergency Medical Condition.** This means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the health of the individual (or, with respect to a pregnant individual, the health of the individual or unborn Child) in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part.

**Emergency Service.** This means a health care service necessary to treat an Emergency Medical Condition including:

- a medical screening examination, as required under section 1867 of the Social Security Act, that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition
- within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required under section 1867 of the Social Security Act to stabilize the patient
- Emergency services as defined under MN statutes 245.462, subdivision 11, and 245.4871, subdivision 14

**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.

**Health Care Provider.** This is any licensed non-Physician (excluding naturopathic providers), including a pharmacist, podiatrist, optometrist or chiropractor, 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.

**Health Care Service.** This means:

- a health care procedure, treatment, or service provided by a health care Facility or a Physician office;
- a health care procedure, treatment, or service provided by a doctor of medicine, doctor of osteopathy, or other health professional within the scope of practice for that professional; or
- the provision of pharmaceutical products or services, medical supplies, or Durable Medical Equipment.

**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.

**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.** These are supportive services, including skilled or non-skilled nursing care or therapy 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.** These are 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 Out-of-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 deductible.

**Over-the-Counter (OTC).** These are items, medical equipment or medicines available without a prescription.

**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.

**Prior Authorization.** This means a determination by HealthPartners medical or dental directors, or their designees, that an Admission, extension of stay, or other Health Care Service (including Prescription Drugs) has been reviewed and that, based on the information provided, it satisfies the utilization review requirements. The Plan will then pay for the covered benefit, provided the general exclusion provisions, and any Deductible, Copayment, Coinsurance, or other requirements have been met.

**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 will be reviewed by the HealthPartners Pharmacy and Therapeutics Committee to establish coverage. This process may take up to six months after market availability.

**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 which are administered in a clinic or Hospital setting 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 Coverage Criteria Policies, 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, 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
PO Box 1309
Minneapolis, MN 55440-1309
Telephone: 952-883-5000
Outside the metro area: 800-883-2177

## 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 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:

- determine its obligation, pursuant to the contract;
- determine whether a benefit reserve has been recorded for the Covered Person; and
- 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

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. Voluntary or involuntary termination of employment (except for gross misconduct) of the Covered Employee, or layoff from employment, 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. A former Spouse is only eligible for continuation if the Spouse was covered under this Plan the day before the entry of a valid decree of dissolution of marriage.
   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. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".
   (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 any time during 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. See "Disabled Employee" below, which describes your rights for coverage as a disabled employee under Minnesota law.

(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.** Under Minnesota law, there is no maximum period of coverage for a former Spouse or dependents who lose coverage due to divorce or legal separation. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".

(5) **Death of Covered Employee.** Under Minnesota law, there is no maximum period of coverage for a surviving Spouse and dependents who lose coverage due to the death of the Covered Employee. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".

(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. See "Disabled Employee" below, which describes your rights for coverage as a disabled employee under Minnesota law.

(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.

**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. If your coverage was terminated because of the death of the Covered Employee, your initial payment is not due until 90 days after you receive notice of the continuation right. 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:
Richfield Public Schools ISD 280
401 W 70th St
Richfield, MN 55423-7555

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:

HealthPartners Medical Claims
PO Box 21024
Eagan, MN 55121

**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 Out-of-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 Out-of-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

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

If your claim for benefits under the Plan is wholly or partially denied, you are entitled to appeal that decision 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 appeal process prior to bringing a civil action. The steps in this appeal process are outlined below.

**Appeal Process.** 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:

HealthPartners Member Services
PO 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 60 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.

## EXTERNAL REVIEW PROCEDURES

You have the right to request external review of any of the following:

- An adverse benefit determination based on judgment of medical appropriateness
- Coverage of claims for the following services received from an Out-of-Network Provider:
  - Air ambulance services
  - Emergency Services
  - Services received in a Network Facility
- 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.

You or your Authorized Representative must request an external review within four months of the adverse decision.

To initiate the external review process, you may submit a written request for an external review to the Plan Manager.

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:** | Richfield Public Schools ISD 280 |
| **Name of the Plan:** | The Plan shall be known as the Richfield Public Schools ISD 280 Medical Benefit Plan which provides employee and dependent medical benefits. |
| **Address of the Plan:** | 401 W 70th St<br>Richfield, MN 55423-7555<br>612-798-6057 |
| **Group Number:** | 41000 |
| **Plan Year:** | The period beginning on each July 1 in which the provisions of the Plan are in effect. |
| **Plan Fiscal Year Ends:** | June 30 |
| **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.) | Richfield Public Schools ISD 280 |
| **Agent for Service of Legal Process:** | General Counsel for Richfield Public Schools ISD 280 |
| **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, Richfield Public Schools ISD 280 is the named Fiduciary.<br><br>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.<br>8170 33rd Avenue South<br>PO Box 1309<br>Minneapolis, MN 55440-1309<br>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. |

## PRESCRIPTION DRUG PROGRAM

Outpatient prescription drugs and other pharmacy items are administered by MaxorPlus. This includes, but is not limited to, glucose monitors, diabetic supplies, growth hormone, blood products, blood derivatives and special dietary supplies for phenylketonuria (PKU).

For more information about the outpatient drug program, call MaxorPlus at 800-687-0707 or go to maxor.com.

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

MaxorPlus will refill a prescription for eye drops 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 31-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 93-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 Covered Person 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.**

If a copayment is required, you must pay one copayment for each 31-day supply or portion thereof, unless otherwise indicated below.

**Outpatient drugs (except as specified below)**

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| **Preferred Pharmacy:**<br>$7 copayment and 100% thereafter per prescription for generic formulary drugs.<br>$11 copayment and 100% thereafter per prescription for brand name formulary drugs.<br>$26 copayment and 100% thereafter per prescription for non-formulary drugs.<br>Deductible does not apply.<br>**Non-Preferred Pharmacy (CVS & Walgreens):**<br>$13 copayment and 100% thereafter per prescription for generic formulary drugs.<br>$22 copayment and 100% thereafter per prescription for brand name formulary drugs.<br>$44 copayment and 100% thereafter per prescription for non-formulary drugs.<br>Deductible does not apply. | Manual reimbursement at network rate less copay of Non-preferred Pharmacy |

**Cost sharing limits for insulin:** MaxorPlus 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 program.

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

**Mail order drugs**

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

**Specialty drugs that are self-administered**

| Network Benefits | Non-Network Benefits |
|---|---|
| 20% of charges incurred, to a maximum of $200 per prescription.<br><br>Deductible does not apply.<br><br>For Network Benefits, specialty drugs are limited to drugs on the Specialty Drug List and must be obtained from a designated vendor. | Manual reimbursement at network rate less copay of Non-preferred Pharmacy |

In order for MaxorPlus 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 above. Manufacturer-funded copayment assistance received by a Covered Person will not apply to the Covered Person's calendar year deductible or out-of-pocket limit.

**Drugs for the treatment of growth deficiency**

| Network Benefits | Non-Network Benefits |
|---|---|
| 80% of the charges incurred. Deductible does not apply.<br><br>For Network Benefits, growth deficiency drugs are limited to drugs on the Specialty Drug List and must be obtained from a designated vendor. | Manual reimbursement at network rate less copay of Non-preferred Pharmacy |

**Tobacco cessation drugs**

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

**Contraceptive drugs**

| Network Benefits | Non-Network Benefits |
|---|---|
| Formulary contraceptives are covered at 100% of the charges incurred. Deductible does not apply. | Manual reimbursement at network rate less copay of Non-preferred Pharmacy |

**ACA preventive medications.** MaxorPlus covers preventive medications currently recommended by the USPSTF with an A or B rating if they are prescribed by your medical provider. Preventive medications are subject to periodic review and modification. Changes would be effective in accordance with the federal rules.

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred. Deductible does not apply. | Manual reimbursement at network rate less copay of Non-preferred Pharmacy |

**Limitations:**

- Certain drugs may require prior authorization as indicated on the formulary. MaxorPlus may require prior authorization for the drug and also the site where the drug will be provided. Certain drugs are subject to the MaxorPlus 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.
- MaxorPlus 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 Program” 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 MaxorPlus 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. The excluded drug list is available at maxor.com.
- Medical devices approved by the FDA will not be covered under the “Prescription Drug Program” 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 designated mail order service are limited to 18 doses per 93-day supply.
  - 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.

Richfield Public Schools has partnered with Rx Valet to offer a program designed to reduce the cost of high-cost medications through various savings initiatives. This benefit provides a $0 cost share for members on high-cost brand and specialty prescription drugs exceeding $400 for a 30-day supply. Please note that this program does not guarantee coverage and is subject to additional prior authorization and approval by the manufacturer. For more information, members can contact the Specialty Drug Administrator at Rx Valet at 706-450-6536.

**AMENDMENT TO THE SUMMARY PLAN DESCRIPTION FOR RICHFIELD PUBLIC SCHOOLS ISD 280**

**Plan A Deductible Medical Option**

**Summary Plan Description**

This Amendment is hereby made a part of the *Summary Plan Description (SPD)*, is effective July 1, 2023, and is as follows:

**Section Prescription Drug Program is added before the Limitations:**

The following actions by a Covered Person or a Covered Person's knowledge of such actions being taken by another, constitute fraud and will result in immediate, indefinite, and permanent termination of all coverage under this Plan for the entire Family unit of which the Covered Person is a member:

1. Attempting to submit a Claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;

2. Attempting to file a Claim for a Covered Person for services that were not rendered or Drugs or other items that were not provided;

3. Providing false or misleading information in connection with enrollment in the Plan;

4. Providing any false or misleading information to the Plan; or

5. Providing any false or misleading information to the Select Drugs and Products Program or those alternate funding programs that it identifies.

The Plan requires Covered Persons to enroll in the Select Drugs and Products Program when individuals are prescribed prescription drugs listed on the Select Drugs and Products List. This Program is paid for by the Plan and helps identify and assist you in working with publicly available funding programs that may help you reduce your out-of-pocket costs. All Covered Persons using listed specialty drugs are required to meet prior authorization, step-therapy, and administrative review criteria, which include enrollment in the Program and adjudication of their Specialty Drug cost by an alternate funding program before meeting Plan coverage criteria. Failure to authorize and complete the requirements of the Select Drugs and Products Program will result in a cost containment penalty equal to a 100% reduction in benefits payable. This will be treated as an adverse benefit determination under the Plan and the Covered Person will have an opportunity to (i) appeal that decision or (ii) comply with the requirements of the Program to avoid the cost containment penalty.

Some alternate funding programs require verification of income as a condition of meeting alternate funding program criteria. In such cases, the Covered Person will be asked to provide this information directly to the alternate funding program, and such information will not be provided to the Plan and is not considered in determining coverage by the Plan.

All Specialty Drug prescriptions paid for by the Plan through the appeals process must be dispensed or coordinated by Maxor. Questions related to the Select Drugs and Products Program may be made directly to the Plan Specialty Contact Center.