



Summary Plan Description

Choice Financial Group Empower HSA Plan

January 1, 2023

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

TABLE OF CONTENTS

Section	Page
About HealthPartners and Your Employer	1
Introduction to the Summary Plan Description.....	2
Summary Plan Description (SPD).....	2
Medical Administrative Services Agreement (ASA).....	2
Conflict with Existing Law	2
Identification Card.....	2
How to use the Network.....	2
About the Network.....	3
Eligibility and Effective Date of Coverage.....	4
Eligibility.....	4
Effective Date of Coverage.....	4
Late Enrollment.....	4
Special Enrollment Period.....	5
Special Rules Relating to Medicaid and the Children’s Health Insurance Program (CHIP)	6
Changes in Benefits.....	6
Termination.....	6
Access to Records and Confidentiality.....	7
Benefits Chart	8
Understanding Your Coverage.....	8
How to Use this Benefits Chart.....	8
How Your Choice of Providers Affects Your Coverage.....	8
Benefits Chart Definitions.....	9
Deductibles and Out-of-Pocket Limits.....	11
Benefit Descriptions.....	12
Ambulance and Medical Transportation.....	12
Behavioral Health Services.....	12
Chiropractic Services.....	15
Clinical Trials	15
Dental Services	16
Diabetes and Hypertension Disease Management Program	18
Diabetic Equipment and Supplies.....	18
Diagnostic Imaging Services	20
Durable Medical Equipment, Prosthetics, Orthotics and Supplies	20
Emergency and Urgently Needed Care Services.....	22
Gene Therapy.....	23
Health Education	23
Hearing Aids.....	24
Home Health Services	24
Home Hospice Services.....	26
Hospital and Skilled Nursing Facility Services	27
Infertility/Fertility Services	30
Laboratory Services.....	30
Mastectomy Reconstruction Benefit.....	31
Medication Therapy Disease Management Program.....	31
Office Visits for Illness or Injury.....	32
Physical Therapy, Occupational Therapy and Speech Therapy	33
Pre-Diabetes Disease Management Program.....	34
Prescription Drugs	34
Preventive Services.....	38
Telehealth/Telemedicine Services.....	42

Transplant Services.....	43
Services Not Covered.....	45
General Definitions.....	48
Disputes and Complaints.....	51
Determination of Coverage.....	51
Complaints.....	52
Conditions.....	52
Rights of Reimbursement and Subrogation.....	52
Coordination of Benefits.....	53
Medicare and the Plan.....	56
Continuation of Group Coverage.....	57
Claims Procedures.....	59
Procedures for Reimbursement of Network Services.....	59
Procedures for Reimbursement of Services.....	59
Time of Notification to Claimant of Claims.....	60
Claim Denials and Claim Appeals Process.....	60
External Review Procedures.....	61
Rights Under ERISA.....	61
Responsibilities of Covered Persons.....	62
Rights Upon Termination or Amendment of the Plan.....	62
Specific Information About the Plan.....	63

HEALTHPARTNERS MISSION

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

ABOUT HEALTHPARTNERS AND YOUR EMPLOYER

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

Employer (“Plan Sponsor”). The Employer has established a Medical Benefit Plan (“the Plan” and/or “this Plan”) to provide medical benefits for Covered Employees and their Covered Dependents (“Covered Persons”). The Plan is “self-insured” which means that the Plan Sponsor pays the claims from its own funding as expenses for Covered Services as they are incurred. The Plan is described in the Summary Plan Description (SPD). The Plan Sponsor has contracted with HPAI to provide access to its Network of Health Care Providers, claims processing 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 federal laws governing welfare health benefits, the requirements of the Internal Revenue Code or ERISA 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.

HealthPartners trademarks. HealthPartners names and logos and all related products and service names, design marks and slogans are the trademarks of HealthPartners or its related companies.

INTRODUCTION TO THE SUMMARY PLAN DESCRIPTION

SUMMARY PLAN DESCRIPTION (SPD)

This Summary Plan Description (this SPD) effective date is the later of January 1, 2023 and the Covered Person's effective date of coverage under the Plan.

This SPD, along with Medical Policies (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. You may access the Coverage Criteria Policies by logging on to your “myHealthPartners” account at healthpartners.com or by calling Member Services.

This SPD should be read completely. Many of its provisions are interrelated; reading just one or two provisions may give you incomplete information regarding your rights and responsibilities under the Plan. 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. You may not, in any way, assign or transfer your rights or benefits under the Plan. In addition, you may not, in any way, assign or transfer your right to pursue any causes of action arising under the Plan including, but not limited to, causes of action for denial of benefits under the Plan.

MEDICAL ADMINISTRATIVE SERVICES AGREEMENT (ASA)

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

CONFLICT WITH EXISTING LAW

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

IDENTIFICATION CARD

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

HOW TO USE THE NETWORK

This SPD describes your Covered Services and how to obtain them. **The Plan provides Network Benefits and 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 logging on to your “myHealthPartners” account at healthpartners.com. If you need assistance locating a Physician or other Health Care Provider in your Network, please contact Member Services.

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.

Effective through the end of the national public health emergency, the following exceptions will be made:

- If a Covered Person is transferred from a Network Hospital that lacks capacity due to the COVID-19 pandemic to another Facility that has capacity, medical transportation from the Network Hospital to an available Facility will be covered at no cost
- If a Covered Person is transferred from a Network Hospital that lacks capacity due to the COVID-19 pandemic to another Facility that has capacity, and is transferred to a Hospital that is an Out-of-Network Hospital, the Out-of-Network Hospital will be covered at the same benefit level that would have applied had the Covered Person received services from a Network Hospital
- Antibody therapy for COVID-19 administered at Out-of-Network antibody infusion sites and/or by Out-of-Network Providers which administer the therapy, will be covered at the same benefit level as a Network site or Provider

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 log on to your “myHealthPartners” 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 and supplies must be obtained from or repaired by approved vendors
- For Specialty Drugs that are self-administered, you must obtain the Specialty Drugs from a Designated Vendor

Call Member Services for more information on 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.

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.

Prior authorization for services. Your Physician may be required to obtain prior authorization for certain services. 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 log on to your "myHealthPartners" account at healthpartners.com for a list of which services require your Physician to obtain prior authorization.

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

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.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

ELIGIBILITY

All employees, as determined by the Plan Sponsor, working 30 hours per week or 130 hours per month (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.

Part-time and seasonal employees are not eligible to enroll in the Plan.

EFFECTIVE DATE OF COVERAGE

The employee's and any dependent's effective date is the first day of the month following or coinciding with the date of hire.

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

For purposes of this provision, "actively at work" is the time period in which an employee is customarily performing all the regular duties of 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

Depending on your circumstances, some of the timeframes described in this section may be extended for the earlier of one year or 60 days after the end of the COVID-19 National Emergency. If you have questions about the timeframes that are applicable to you, please contact your employer.

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

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, the Medical Policies and your Drug Formulary.

The Medical Policies (Coverage Criteria Policies) list specific criteria that must be met for certain supplies, Health Care Services, behavioral health services 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 reviews and updates Coverage Criteria Policies and Formularies regularly. To learn more about Coverage Criteria Policies or your Formulary, log on to your “myHealthPartners” account at healthpartners.com or call Member Services.

The Network Benefits are intended to constitute a high deductible health plan under Internal Revenue Code section 223.

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 definition of “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.

Under the No Surprises Act, Health Care Providers and Facilities are required to provide patients with a plain-language consumer notice explaining that patient consent is required to receive non-emergency care on an Out-of-Network basis before that Provider can bill at the higher Out-of-Network rate.

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 medical/surgical 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.

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.

A charge is incurred for covered ambulatory medical, Inpatient professional fees, and surgical services on the date the service or item is provided. A charge is incurred for covered Inpatient Facility fees on the date of Admission to a hospital. To be covered, a charge must be incurred on or after the Covered Person's effective date and on or before the termination date.

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

For services provided by a Network Provider:

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

For services provided by 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.

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

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 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 Benefits above the usual and customary charge (see definition of Charge) do not apply to the Out-of-Pocket limit.

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

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

DEDUCTIBLES AND OUT-OF-POCKET LIMITS

Calendar Year Deductible

Individual Calendar Year Deductible

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
\$3,000	\$6,000

Individual + One Dependent Calendar Year Deductible

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
\$4,500	\$9,000

Family Calendar Year Deductible

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
\$6,000	\$12,000

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

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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
\$6,000	\$18,000

Individual + One Dependent Calendar Year Out-of-Pocket Limit

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
\$9,000	\$24,000

Family Calendar Year Out-of-Pocket Limit

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
\$12,000	\$36,000

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

Out-of-Network Benefits for transplant surgery do not apply to the Out-of-Pocket Limit and will not be paid at 100% once the Out-of-Pocket Limit has been met.

Out-of-Network Benefits above the usual and customary charge (see definition of Charge) do not apply to the Out-of-Pocket Limit.

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.

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.

Log on to your "myHealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	80% of the Charges incurred, after you pay the Network Deductible. Subject to the Network Out-of-Pocket Limit. The amount you pay for air ambulance services will be determined based on the requirements of the No Surprises Act and its implementing regulations.

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.

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:

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). Log on to your "myHealthPartners" account at healthpartners.com 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 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’s assistant
- Psychological testing services for the purposes of determining the differential diagnoses and treatment planning for patients currently receiving behavioral health services
- Day treatment and intensive Outpatient services in a licensed program
- Partial hospitalization services in a licensed Hospital or community mental health center
- Psychotherapy and nursing services provided in the home
- Treatment for gender dysphoria
- Medically Necessary Applied Behavioral Analysis (ABA) prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed Physician or a licensed psychologist. For other autism services covered under this Benefits Chart, see the habilitative benefit under Physical Therapy, Occupational Therapy and Speech Therapy.

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

<u>Network Benefits</u> 80% of the Charges incurred, after you pay the Deductible.	<u>Out-of-Network Benefits</u> 60% of the Charges incurred, after you pay the Deductible.
--	---

Group therapy

<u>Network Benefits</u> 80% of the Charges incurred, after you pay the Deductible.	<u>Out-of-Network Benefits</u> 60% 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 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.

<u>Network Benefits</u> 80% of the Charges incurred, after you pay the Deductible.	<u>Out-of-Network Benefits</u> 60% 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). Log on to your “myHealthPartners” account at healthpartners.com 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
- Opiate replacement therapy including methadone and buprenorphine treatment
- Day treatment and intensive Outpatient services in a licensed program

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% 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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible.

Not Covered:

- Halfway houses, group homes, extended care Facilities, shelter services, transitional services, housing support programs, foster care services and any comparable Facilities, services or programs
- 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, rendered to diagnose and treat acute neuromusculoskeletal conditions.

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

Log on to your “myHealthPartners” account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible. 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 acute 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.

Log on to your “myHealthPartners” account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

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

The Plan covers services as described below. Log on to your “myHealthPartners” account at healthpartners.com 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 an implant-supported dental prosthetic treatment is pursued, the accidental dental benefit will be applied to the prosthetic procedure. Benefits are limited to the amount that would be paid toward the placement of a removable dental prosthetic appliance that could be used in the absence of implant treatment.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible.

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

Medical referral dental services

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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% 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
- Children ages 5 through 12 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 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.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible.

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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible.

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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% 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 Copayment, conditions and limitations as durable medical equipment.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible.

Treatment of temporomandibular disorder (TMD) and craniomandibular disorder (CMD). The Plan covers surgical and non-surgical treatment of temporomandibular disorder (TMD) and craniomandibular disorder (CMD) when such care is Medically Necessary. Dental services which are not required to directly treat TMD or CMD are not covered.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% 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
- Oral surgery to remove wisdom teeth
- Orthognathic treatment or procedures and all related services

DIABETES AND HYPERTENSION DISEASE MANAGEMENT PROGRAM

Covered Services:

A Diabetes and/or Hypertension Disease Management Program is available through Omada Health for eligible Covered Persons with diabetes and/or high blood pressure. The program uses connected devices and a health coach to create lasting behavior changes by focusing on weight loss, exercise, behavior modification and health education.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	Not applicable.

DIABETIC EQUIPMENT AND SUPPLIES

Covered Services:

The Plan covers Physician prescribed medically appropriate and necessary Drugs and supplies used in the management and treatment of diabetes for Covered Persons with gestational, Type I or Type II diabetes including durable diabetic equipment and disposable supplies, as described below. Log on to your “myHealthPartners” account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply. Insulin and medications for diabetes are covered as Outpatient Drugs under the “Prescription Drugs” section.

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.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
<p>Pumps received through a pharmacy: 80% of the Charges incurred, after you pay the Deductible.</p> <p>Pumps received through a non-pharmacy provider: 80% of the Charges incurred, after you pay the Deductible, if purchased from an approved vendor.</p>	<p>60% of the Charges incurred, after you pay the Deductible.</p>

All other diabetic durable equipment and supplies

Durable diabetic equipment and supplies. These include continuous glucose monitoring system (CGMS), transmitter, sensors and receivers, diabetic blood glucose monitors and control/calibrating solutions (for checking accuracy or testing equipment and test strips).

Disposable diabetic supplies. These are one-time use supplies, including syringes, lancets, lancet devices, blood and urine ketone test strips, and needles.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
<p>If received through a pharmacy: Diabetic supplies on the Commercial HSA Preventive Drug List: 100% of the Charges incurred. Deductible does not apply. All other diabetic supplies purchased at a pharmacy: 80% of the Charges incurred, after you pay the Deductible.</p> <p>If received through a non-pharmacy provider: 80% of the Charges incurred, after you pay the Deductible, if purchased from an approved vendor.</p>	<p>60% of the Charges incurred, after you pay the Deductible.</p>

Limitations:

- No more than a 93-day supply of diabetic supplies is covered and dispensed at a time
- 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

Not Covered:

- 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)

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

Services for Illness or Injury

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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible.

All other Outpatient diagnostic imaging services

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

Covered Services:

The Plan covers the following Medically Necessary equipment, supplies and services. Log on to your “myHealthPartners” account at healthpartners.com 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
- Prosthetics, including breast prostheses, artificial limbs and artificial eyes (including polishing and adjustments) and related supplies
- Hair prostheses (wigs) for hair loss resulting from a medical condition
- Orthotics
- Medical supplies, including 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 Physician

Diabetic equipment and supplies are covered under the “Diabetic Equipment and Supplies” section.

Hearing aids are covered under the “Hearing Aids” section.

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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible.

Oral amino acid based elemental formula

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible.

All other durable medical equipment, prosthetics, orthotics and supplies

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible.

Lifetime Maximum Benefit for Hair Prostheses (wigs)

<u>Network Benefits</u>	<u>Non-Network Benefits</u>
\$1,000	\$1,000

The Lifetime Maximum Benefit for hair prostheses (wigs) for hair loss resulting from a medical condition for Network Benefits and Non-Network Benefits is combined.

Limitations:

Coverage of durable medical equipment is limited by the following:

- 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 oral appliances for cleft lip and cleft palate.
- The Plan reserves the right to determine if an item will be approved for rental vs. purchase
- Durable medical equipment 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 (1) 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 any 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
- 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
- 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.

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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	80% 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: (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. Emergency care also includes an immediate response service available on a 24-hour, seven-day-a-week basis for individuals having a psychiatric crisis, a mental health crisis, or a mental health emergency.

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.

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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	80% of the amount determined under the law, after you pay the Network Deductible. Subject to the Network Out-of-Pocket Limit. 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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible. Out-of-Network professional fees will be paid at the Network Inpatient Hospital Services Benefit level if the Covered Person is admitted Inpatient to a Network Hospital through the emergency room.	80% of the amount determined under the law, after you pay the Network Deductible. Subject to the Network Out-of-Pocket Limit. 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.

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

Limitations:

- Gene therapy must be provided by a Designated Provider
- Specific types of gene therapy are limited to therapies and conditions specified in the Coverage Criteria Policies. Log on to your “myHealthPartners” account at healthpartners.com 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).

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

HEARING AIDS

Covered Services:

The Plan covers external basic hearing aids (including osseointegrated or bone anchored) for Covered Persons who have hearing loss that is not correctable by other covered procedures. Log on to your “myHealthPartners” account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% 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, regardless of whether the previous hearing aid was covered under this SPD. 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.

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 life-threatening, non-curable condition which has a prognosis of two years or less. Additional palliative care visits are eligible under the home health services benefit if you are homebound and meet all other requirements defined in this section.

Home health services are eligible 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

Log on to your “myHealthPartners” account at healthpartners.com 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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible.

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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% 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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% 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

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

Each visit provided under the Network Benefits and 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
- Private duty nursing

HOME HOSPICE SERVICES

Definitions:

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

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

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

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 curative treatment for their terminal illness for the period they are enrolled in the Home Hospice Program.

Eligibility. In order to be eligible to be enrolled in the Home Hospice Program, a Covered Person must: (1) be a terminally ill patient (prognosis of six months or less); (2) have chosen a palliative treatment focus (i.e., emphasizing comfort and supportive services rather than treatment attempting to cure the disease or condition); and (3) continue to meet the terminally ill prognosis as determined by HealthPartners medical director or 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 are covered
 - One or more periods of Continuous Care in the Covered Person's home or in a setting which provides day care for pain or symptom management, when Medically Necessary, will be covered
- **Inpatient services:** The Plan covers Medically Necessary Inpatient services.
- **Other services:**
 - Respite care is covered for care in the Covered Person's home or in an appropriate Facility, to give the patient's primary caregivers (i.e., family members or friends) rest and/or relief when necessary in order to maintain a terminally ill patient at home
 - Medically Necessary medications for pain and symptom management
 - Medically Necessary semi-electric Hospital beds and other durable medical equipment are covered
 - Medically Necessary emergency and non-emergency care are covered

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% 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.

Log on to your “myHealthPartners” account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

Not Covered:

- Rest and respite services, except as described above
- Custodial or Maintenance 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.

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. Log on to your “myHealthPartners” account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

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.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending Provider, after consulting with the mother, from discharging the mother or the newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% 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, administration of Specialty Drugs, 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.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% 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”.

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. Log on to your “myHealthPartners” account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% 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 toward the maximums shown above.

Limitations:

- The Plan requires prior authorization for certain Drugs and the site where the Drug will be administered. The Formulary and information on Drugs with limitations are available by calling Member Services or logging on to your “myHealthPartners” account at healthpartners.com.

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 and laboratory work related to Covered Services.

In addition, the Plan covers assisted reproductive technology (ART) procedures such as in-vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian transfer (ZIFT) and intracytoplasmic sperm injection (ICSI). cryopreservation, thawing and up to one year of embryo storage is included.

Fertility drugs are covered under the “Prescription Drugs” section.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible.

Lifetime Maximum Benefit for fertility services, including assisted reproductive technology (ART) procedures and fertility drugs

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
\$30,000	\$30,000

The Lifetime Maximum Benefit for fertility services and fertility drugs for Network Benefits and Out-of-Network Benefits is combined.

Not Covered:

- Reversal of sterilization
- Fertility treatment after reversal of sterilization
- Sperm and ova storage
- Embryo storage beyond one year
- Procurement and fees associated with donor sperm and ova
- 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.

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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

Prostate-specific antigen (PSA) testing

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible.

For Illness or Injury

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible.

COVID testing. Effective through the end of the national public health emergency:

- Coverage for the testing of COVID-19 and the associated provider visit will be covered at no cost. Services may be performed by a Network or Out-of-Network Provider.
- Over-the-counter COVID-19 diagnostic tests completed at home without medical supervision are eligible for coverage. Tests are covered up to \$12 per test and up to eight tests per month, per individual. A test refers to a single nose or throat swab – if a test kit you purchase contains multiple swabs, each swab is counted separately. All antigen diagnostic tests and molecular diagnostic tests with an FDA-issued Emergency Use Authorization (EUA) are covered. Tests can be purchased through your pharmacy or reimbursed if you paid out-of-pocket. Online reimbursement is available through the Covered Employee’s healthpartners.com account and includes the ability to submit for all dependents.

MASTECTOMY RECONSTRUCTION BENEFIT

Covered Services:

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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding 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. Log on to your “myHealthPartners” account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
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 and administration of Specialty Drugs
- Blood, blood products (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.

Log on to your “myHealthPartners” account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

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

Office visits

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible.

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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible.

Injections administered in a Physician’s office, other than immunizations

Allergy injections

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible.

All other injections

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% 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. The Formulary and information on Drugs with limitations are available by calling Member Services or logging on to your “myHealthPartners” account at healthpartners.com.

Not Covered:

- Court-ordered services
- 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

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 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.

Log on to your “myHealthPartners” account at healthpartners.com 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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible.
	Physical and occupational therapy combined are limited to 20 visits per Calendar Year.
	Speech therapy is limited to 20 visits per Calendar Year.

Habilitative Care

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% of the Charges incurred, after you pay the Deductible. Physical, occupational and speech therapy, combined, are limited to 20 visits per Calendar Year.

Not Covered:

- Massage therapy, except as described above
- Maintenance Care

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.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	Not applicable.

PRESCRIPTION DRUGS

Definitions:

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

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

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

Non-Formulary Drug. This is a Prescription Drug, approved by the Food and Drug Administration (FDA), that is not on the Formulary, is Medically Necessary and is not Investigative or otherwise excluded under this Plan.

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.

Preventive Drug List. This is a current list, which may be revised from time to time, of certain Formulary preventive prescription drugs and certain diabetic supplies, covered under this Plan. You may access the Preventive Drug List by logging on to your “myHealthPartners” account at healthpartners.com or by calling Member Services.

Specialty Drugs. These medications are usually prescribed by doctors whose focus is on the treatment of chronic and complex diseases. They usually require more management, have a high price and aren’t always stocked at retail pharmacies. Prescriptions for these medications must be filled at a specialty pharmacy and are often covered at a different benefit than non-specialty medications. Specialty drug designations are indicated on the Formulary and may be revised from time to time. Log on to your “myHealthPartners” account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

Covered Services:

Medically Necessary Drugs are based on Coverage Criteria Policies and Formulary guidelines. Log on to your “myHealthPartners” account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

The Plan covers Prescription Drugs and medications, which can be self-administered or are administered in a Physician’s office.

Diabetic equipment and supplies are covered under the “Diabetic Equipment and Supplies” section.

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

Drugs on the Commercial HSA Preventive Drug List

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred for Formulary Drugs from the Commercial HSA Preventive Drug List. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

All other Outpatient drugs (except as specified below)

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
\$10 Copayment and 100% thereafter per prescription for Generic Formulary Drugs.	60% of the Charges incurred, after you pay the Deductible.
\$35 Copayment and 100% thereafter per prescription for Brand Name Formulary Drugs.	
\$60 Copayment and 100% thereafter per prescription for Non-Formulary Drugs.	
Deductible applies.	

Cost-sharing limits for insulin. The Plan limits your cost-sharing on prescription insulin to no more than the net price of the prescription insulin drug. This applies at the point of sale, including Deductible payments and the cost-sharing amounts charged once the Deductible is met. Cost-sharing means a Deductible payment, Copayment, or

Coinsurance amount that you must pay for covered prescription insulin in accordance with the terms and conditions of this Plan. The net price is HealthPartners' cost for prescription insulin, including any rebates or discounts received by or accrued directly or indirectly to HealthPartners from a drug manufacturer or pharmacy benefits manager.

Mail order drugs

<p><u>Network Benefits</u></p> <p>You may also get Outpatient Prescription Drugs that can be self-administered through the designated mail order service.</p> <p>Drugs on the Commercial HSA Preventive Drug List ordered through this service are covered at the benefit percent shown under “Outpatient drugs” in the “Drugs on the Commercial HSA Preventive Drug List” section above for each 93-day supply or portion thereof. Deductible does not apply.</p> <p>Outpatient drugs ordered through this service are covered at the benefit percent shown under “Outpatient drugs” in the “All other Outpatient drugs” section above, subject to two Copayments for each 93-day supply or portion thereof. Deductible applies.</p> <p>Specialty Drugs are not available through the mail order service.</p>	<p><u>Out-of-Network Benefits</u></p> <p>Mail order drugs are only available through the designated mail order service.</p> <p>See Network Benefits.</p>
---	---

Specialty Drugs that are self-administered

<p><u>Network Benefits</u></p> <p>80% of the Charges incurred after you pay the Deductible, up to a maximum Copayment of \$200 per prescription.</p> <p>For Network Benefits, Specialty Drugs must be obtained from a Designated Vendor.</p>	<p><u>Out-of-Network Benefits</u></p> <p>60% of the Charges incurred, after you pay the Deductible.</p>
---	--

Growth deficiency drugs

<p><u>Network Benefits</u></p> <p>80% of the Charges incurred, after you pay the Deductible.</p> <p>For Network Benefits, growth deficiency drugs must be obtained from a Designated Vendor.</p>	<p><u>Out-of-Network Benefits</u></p> <p>60% of the Charges incurred, after you pay the Deductible.</p>
---	--

Fertility drugs

<p><u>Network Benefits</u></p> <p>80% of the Charges incurred, after you pay the Deductible.</p> <p>Fertility drugs must be obtained from a Designated Vendor.</p>	<p><u>Out-of-Network Benefits</u></p> <p>No coverage.</p>
---	--

Lifetime Maximum Benefit for fertility services, including assisted reproductive technology (ART) and fertility drugs

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
\$30,000	\$30,000

The Lifetime Maximum Benefit for fertility services and fertility drugs for Network Benefits and Out-of-Network Benefits is combined.

Tobacco cessation drugs

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

All FDA-approved tobacco cessation drugs (including over-the-counter drugs) are covered and must be prescribed by a licensed provider.

Contraceptive drugs

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
Formulary contraceptives are covered at 100% of the Charges incurred. Deductible does not apply. If a Physician requests that a Non-Formulary contraceptive Drug be dispensed as written, the Drug will be covered at 100%. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

Limitations:

- Certain drugs may require prior authorization or have quantity limits. The Plan may require prior authorization for the Drug and also the site where the Drug will be provided. The Formulary and information on drugs with limitations are available by calling Member Services or logging on to your “myHealthPartners” account at healthpartners.com.
- Certain Drugs may be subject to HealthPartners’ trial drug 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. Your first three fills 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 prescribed supply.
- Biosimilar drugs, regardless of interchangeability status, are not considered Generic Drugs and are not covered under the Generic Drug benefit. A biosimilar drug is a Prescription Drug that the FDA has determined is highly similar to a biological Brand Name Drug. HealthPartners will review each biosimilar drug and establish Formulary, coverage and specialty designations.

- Only medical devices approved by the FDA and included on the Formulary are covered under the “Prescription Drugs” section. All other covered medical devices are generally submitted and reimbursed under your medical benefits.
- The Plan 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 Drugs” section, you may receive up to a 31-day supply per prescription
- A 93-day supply will be covered and dispensed at a time only at pharmacies that participate in the HealthPartners extended day supply program
- New prescriptions to treat certain chronic conditions are limited to a 31-day supply
- No more than a 31-day supply of Specialty Drugs will be covered and dispensed at a time, unless it’s a manufacturer supplied Drug that cannot be split that supplies the Covered Person with more than a 31-day supply
- If you request a Brand Name Drug when there is a generic equivalent, the Brand Name Drug will be covered up to the Charge that would apply to the Generic Drug, minus any required Copayment
- If a Physician requests that a Brand Name Drug be dispensed as written (DAW), the drug will be paid at the Non-Formulary benefit

Not Covered:

- Replacement of Prescription Drugs, equipment and supplies due to loss, damage or theft
- Nonprescription (over the counter) drugs, including, but not limited to, vitamins, supplements and homeopathic remedies, unless listed on the Formulary and prescribed by a Physician or legally authorized Health Care Provider under applicable state and federal law
 - The Plan does cover over-the-counter ACA preventive medications as specified above and FDA approved over-the-counter contraceptives for females
- 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
 - The Plan does cover off-label use of Drugs that are determined to be Medically Necessary
- Medical foods, unless listed on the Formulary and prescribed by a Physician or legally authorized Health Care Provider under applicable state and federal law
- 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 at healthpartners.com.
- Drugs 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
- All drugs used for the treatment of sexual dysfunction
- Weight loss drugs

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 of the Centers for Disease Control and Prevention with respect to the individual
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration
- With respect to women, preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration

Log on to your “myHealthPartners” account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

ACA mandated preventive services are covered as follows:

Routine health exams and periodic health assessments. A Physician or Health Care Provider will counsel Covered Persons as to how often health assessments are needed based on age, sex and health status of the Covered Person. This includes screening and counseling for tobacco use and all FDA approved tobacco cessation medications including over-the-counter drugs (as shown in the “Prescription Drugs” section).

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% 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.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

Routine prenatal care and exams

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

Professional voluntary family planning services. This includes services to prevent or delay a pregnancy, including counseling and education. Services must be provided by a licensed provider.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

Adult immunizations

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% 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), breast pumps, human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus (HIV) and all FDA approved contraceptive methods as prescribed by a Physician, sterilization procedures, education and counseling. (See the “Prescription Drugs” section for coverage of contraceptive drugs.) 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.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

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

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

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

Routine eye exams

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

Routine hearing exams

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

Ovarian cancer surveillance tests 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 federal Food and Drug Administration or by the National Cancer Institute.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
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.

Peak flow meters for Covered Persons diagnosed with asthma. Must be prescribed by a licensed provider.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

Glucose meters prescribed by a licensed provider (other than continuous glucose monitoring systems which are covered under the “Diabetic Equipment and Supplies” section)

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply. Glucose meters are limited to meters on the Formulary and must be obtained from a pharmacy.	60% of the Charges incurred, after you pay the Deductible.

Retinopathy screening for Covered Persons diagnosed with diabetes

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

Hemoglobin A1C testing for Covered Persons diagnosed with diabetes

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

International normalized ratio (INR) testing

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

Low-density lipoprotein (LDL) testing

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
100% of the Charges incurred. Deductible does not apply.	60% of the Charges incurred, after you pay the Deductible.

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.

TELEHEALTH/TELEMEDICINE SERVICES

Definitions:

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.

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.

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.

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

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

<u>Network Benefits</u> 80% of the Charges incurred, after you pay the Deductible.	<u>Out-of-Network Benefits</u> 60% of the Charges incurred, after you pay the Deductible.
--	---

E-visits

<u>Network Benefits</u> 80% of the Charges incurred, after you pay the Deductible.	<u>Out-of-Network Benefits</u> 60% of the Charges incurred, after you pay the Deductible.
--	---

Video visits

<u>Network Benefits</u> Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	<u>Out-of-Network Benefits</u> 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 Drugs and multiple transplants for a related cause. Transplant services do not include other organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, except surgical implantation of an FDA approved Ventricular Assist Device (VAD) or total artificial heart, functioning as a temporary bridge to heart transplantation.

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. Log on to your “myHealthPartners” account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply and to view a list of Designated Transplant Centers.

<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
80% of the Charges incurred, after you pay the Deductible.	60% 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.
- 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

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 our Coverage Criteria Policies and Formulary. Log on to your "myHealthPartners" account 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.
- 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
- Oral surgery to remove wisdom teeth
- Orthognathic treatment or procedures and all related services

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, scar revision surgery and port wine stain removal. This exclusion does not apply to services for Reconstructive Surgery and emergency care required due to complications of Cosmetic Surgery.

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

Reproductive and maternity care

- Sperm and ova storage
- Embryo storage beyond one year
- Reversal of sterilization
- Fertility treatment after reversal of sterilization
- Procurement and fees associated with donor sperm and ova
- Surrogacy/gestational carrier compensation, services and fees
- Maternity services for a surrogate/gestational carrier not covered under this SPD
- Elective home births
- Elective abortions, except in the case of rape or incest, or in situations where the life of the mother would be endangered if the fetus is carried to full term

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.
- 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

- Acupuncture
- Services provided by naturopathic Providers
- Music therapy
- Massage therapy as a standalone treatment

- Routine foot care, unless you have one of the conditions (for example, diabetes) listed in our Coverage Criteria Policies. Call Member Services or log on to your “myHealthPartners” 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 and any comparable Facilities, services or programs
- 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.
- Gender confirmation surgeries

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

- 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
- Biofeedback for weight loss
- Inpatient or day treatment programs for weight loss
- Weight loss drugs
- All weight loss/bariatric surgery

All other exclusions

- 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.
- 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 our Coverage Criteria Policies for the device or service
- Treatment, procedures, services, supplies or Drugs received when you are not covered under this Plan
- Travel, transportation, meals or lodging expenses
- 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

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 logging on to your “myHealthPartners” account at healthpartners.com.

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

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

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

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 under Section 609 of the Employee Retirement Income Security Act (ERISA) and its implementing regulations) 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. **Disabled Child.** This is a Covered Employee's dependent Child as defined above, who is (a) incapable of self-sustaining employment by reason of intellectual disability, mental illness or disorder, or physical disability; and (b) chiefly dependent on the Covered Employee for support and maintenance. The disability must have come into existence prior to the attainment of the limiting age as described in Child above. The Covered Employee must give the Plan Manager a written request for coverage of a disabled child. The request must include written proof of disability and must be approved by the Plan Manager, in writing. The Plan Manager must receive the request within 31 days of the date an already enrolled dependent becomes eligible for coverage under this definition. The Plan Manager reserves the right to periodically review disability, provided that after the first two years, the Plan Manager will not review the disability more frequently than once every 12 months.
4. **Domestic Partner.** This is a Covered Employee's spousal equivalent, provided the Covered Employee and the domestic partner:
 - share the same regular and permanent residence; and
 - are jointly responsible for basic living expenses; and
 - are not married to anyone and have been each other's sole domestic partner for at least 12 months; and
 - are each 19 years of age or older; and
 - are each mentally competent to consent to a contract; and
 - have completed the form required by the Plan Sponsor for coverage of a domestic partner and have agreed to any conditions specified in that form.

After terminating a partnership, there will be a 12 month Waiting Period to cover the same partner again or a new partner. A Covered Employee may also enroll the Eligible Dependent Child(ren) of their domestic partner for coverage under this Plan, so long as the domestic partner remains eligible and enrolled. For purposes of this coverage, the Child of the Covered Employee's domestic partner will be treated as the Covered Employee's step-Child. Domestic partners and their Eligible Dependent Children are eligible for continuation under the Plan.

Enrollment Date. This means the first day of coverage under the health benefit plan or the first day of the Waiting Period, if earlier.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

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

Medically Necessary Care. This is Health Care Services and Prescription Drug use that are appropriate in terms of type, frequency, level, setting and duration to your diagnosis or condition, diagnostic testing and preventive services. Medically necessary care, as determined by the Plan, must be:

- Appropriate for the symptoms, diagnosis or treatment of your medical condition;
- Consistent with evidence-based standards of medical practice where applicable;
- Not primarily for your convenience or that of your family, your Physician, or any other person; and
- The most appropriate and cost-effective level of medical services, Prescription Drugs or supplies that can be safely provided. When applied to Inpatient care, it further means that the medical symptoms or conditions require that the medical services or supplies cannot be safely provided in a lower level of care setting.

The fact that a Physician, participating provider, or any other provider, has prescribed, ordered, recommended or approved a treatment, service or supply, or has informed you of its availability, does not in itself make it medically necessary.

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

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.

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

DISPUTES AND COMPLAINTS

DETERMINATION OF COVERAGE

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

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

Coverage determinations are based on the Medical Coverage Criteria 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 Department
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 844-732-3545

CONDITIONS

RIGHTS OF REIMBURSEMENT AND SUBROGATION

If services are provided or paid for under the Plan to treat an Injury or Illness: (1) caused by the act or omission of another party; (2) covered by no fault insurance or other auto insurance or employers liability laws; (3) available or required to be furnished by or through national or state governments or their agencies; or (4) sustained on the property of a third party, the Plan Sponsor or its designee has the right to recover the reasonable value of services and payments made. This right shall be by reimbursement and subrogation. The right of reimbursement means you must repay the Plan Sponsor or its designee at the time you make any recovery. Recovery means all amounts received by you from any persons, organizations or insurers by way of settlement, judgment, award or otherwise on account of such Injury or Illness. The right of subrogation means that the Plan Sponsor or its designee may make claim in your name or the Plan Sponsor's name against any persons, organizations or insurers on account of such Injury or Illness. Attorneys' fees and expenses incurred by a Covered Person in connection with the recovery of monies from third parties may not be deducted from subrogation/reimbursement amounts, unless agreed to by the Plan Sponsor in its discretion.

In addition, the Plan will have a lien on any amounts payable by a third party or under an insurance policy or program, to the extent covered expenses are paid by the Plan Sponsor's Medical Benefit Plan.

The rights of reimbursement and subrogation apply whether or not the Covered Person has been fully compensated for losses or damages by any recovery of payments, and the Plan Sponsor or its designee will be entitled to immediately collect the present value of subrogation rights from said payments.

If, after recovery of any payments, you receive services or incur expenses on account of such Injury or Illness, you may be required to pay for such services or expenses. The total of all reimbursement and payments will not exceed your recovery.

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, medical payments coverage, other substitute coverage or any other right of recovery, whether based on tort, contract, equity or any other theory of recovery. The right of reimbursement is binding upon you, your legal representative, your heirs, next of kin and any trustee or legal representative of your heirs or next of kin in the event of your death. Any amounts you receive from such a recovery must be held in trust for the Plan's benefit to the extent of subrogation claims.

You agree to cooperate fully in every effort by the Plan Sponsor or its designee to enforce the rights of reimbursement and subrogation. You also agree that you will not do anything to interfere with those rights. You agree to promptly inform the Plan Sponsor in writing of any situation or circumstance which may allow the Plan Sponsor to invoke its rights under this section.

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 This Plan's benefits.** The benefits of This Plan will be reduced by the benefits that would be payable for the Allowable Expenses under the other plans, whether or not claim is made. In no event will This Plan pay benefits which, combined with the benefits of the other plans, total more than the Allowable Expenses under This Plan. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.
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

Depending on your circumstances, some of the timeframes described in this section may be extended for the earlier of one year or 60 days after the end of the COVID-19 National Emergency. If you have questions about the timeframes that are applicable to you, please contact your employer or your employer's COBRA administrator.

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

1. **Qualifying events.** Coverage under the Plan may be continued by a Covered Employee, Covered Dependent Spouse and other Covered Dependents, enrolled at the time coverage would otherwise end, or a child born to or placed for adoption with the Covered Employee during the period of continuation coverage, as a result of one of the following qualifying events:
 - a. Termination of employment (except for gross misconduct) of the Covered Employee, or reduction in hours resulting in a loss of group coverage.
 - b. Death of the Covered Employee.
 - c. Divorce or legal separation of the Covered Employee.
 - d. Loss of eligibility as a Covered Dependent child.
 - e. Initial enrollment of the Covered Employee for Medicare.
 - f. For a retired Covered Employee, Spouse and other dependents, the bankruptcy filing by a former Employer, under Title XI, United States Code, on or after July 1, 1986.
2. **Duration of continuation coverage.** The maximum period coverage can be continued depends on the qualifying event. Continuation coverage may be terminated earlier as shown below. The maximum period of continuation coverage starts on the day of the qualifying event.
 - a. **Maximum period**
 - (1) **Termination and reduced hours.** The maximum period of continuation coverage is 18 months. If a second qualifying event, other than the Employer's bankruptcy, occurs during the 18 months, the maximum period of continuation coverage is 36 months.
 - (2) **Disabled Covered Employee, Covered Dependent Spouse or Covered Dependent child.** If the Covered Employee, Covered Dependent Spouse or other Covered Dependent is disabled under Title II or XVI of the Social Security Act, at the time of the termination of employment, or reduced hours of the Covered Employee, or within the first 60 days of continuation of coverage, the 18-month maximum continuation period may be extended to 29 months. The disabled person must notify the Plan Sponsor within 60 days of the date of determination of disability, and within the initial 18-month continuation period. If a second qualifying event (other than bankruptcy) occurs during the extended 29-month period, the maximum period of continuation coverage is 36 months.
 - (3) **Bankruptcy.** In the case of bankruptcy of a retired Covered Employee's former Employer, the maximum period of continuation coverage is until the death of the retired Covered Employee. In the case of the surviving Spouse or dependent children of the retired Covered Employee, the maximum period of continuation coverage is 36 months after the death of the retired Covered Employee.
 - (4) **Divorce or legal separation.** The maximum period of coverage for a former Spouse or dependents who lose coverage due to divorce or legal separation is 36 months.
 - (5) **Death of Covered Employee.** The maximum period of coverage for a Covered Dependent surviving Spouse and Covered Dependents who lose coverage due to the death of the Covered Employee is 36 months.

(6) **Other qualifying events.** The maximum period of continuation coverage for all other qualifying events is 36 months.

b. Earlier termination

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

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

3. Election of continuation coverage

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

4. Procedures for providing notices required under this continuation of group coverage section

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

- c. Your notice must be sent to:

Choice Financial Group
4501 23rd Street South
Fargo, ND 58104

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

CLAIMS PROCEDURES

Depending on your circumstances, some of the timeframes described in this section may be extended for the earlier of one year or 60 days after the end of the COVID-19 National Emergency. If you have questions about the timeframes that are applicable to you, please contact Member Services.

PROCEDURES FOR REIMBURSEMENT OF NETWORK SERVICES

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

PROCEDURES FOR REIMBURSEMENT OF SERVICES

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

Send itemized bills to:

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

Time of payment of claims. Benefits will be paid under the Plan within a reasonable time period.

Payment of claims. Payment will be made according to the Plan Sponsor's coverage guidelines. All or any portion of any benefits for 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. Your Plan provides for two levels of appeal to the named Fiduciary of your Plan or its delegate. You may also have the right to an external review as described below. You must exhaust the first and second levels of the appeal process prior to bringing a civil action under section 502(a) of ERISA. The steps in this appeal process are outlined below.

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

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

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

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

The time period may be extended if you agree.

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

All notifications described above will comply with applicable law.

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

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

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

The time periods may be extended if you agree.

All notifications described above will comply with applicable law.

EXTERNAL REVIEW PROCEDURES

You 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.

RIGHTS UNDER ERISA

As a participant under the Plan, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without Charge, at the Plan Sponsor's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Sponsor, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable Charge for the copies.

Receive a summary of the Plan's financial report. The Plan Sponsor is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan or the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “Fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without Charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Sponsor to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your right, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Sponsor, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue Northwest, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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

The federal government requires that the following information be furnished for the Plan:

Employer:	Choice Financial Group
Name of the Plan:	The Plan shall be known as the Choice Financial Group Empower HSA Plan which provides employee and dependent medical benefits.
Address of the Plan:	4501 23 rd Street South Fargo, ND 58104 701-746-6010
Group Number:	36698
IRS Employer Identification Number:	45-0117790
Plan Identification Number:	503
Plan Year:	The period beginning on each January 1 in which the provisions of the Plan are in effect.
Plan Fiscal Year Ends:	December 31
Plan Sponsor: (is ultimately responsible for the management of the Plan; may employ or contract with persons or firms to perform day-to-day functions such as processing claims and performing other Plan-connected services.)	Choice Financial Group
Agent for Service of Legal Process:	General Counsel for Choice Financial Group
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, Choice Financial Group is the named Fiduciary. Solely for purposes of determining coverage of claims, HealthPartners Administrators, Inc. is the named Fiduciary.
Funding:	Claims under the Plan are paid from the general funds of the Employer.
Plan Manager: (provides administrative services to the Plan Sponsor in connection with the operation of the Plan, such as processing of claims and other functions, as may be delegated to it.)	HealthPartners Administrators, Inc. 8170 33 rd Avenue South P.O. Box 1309 Minneapolis, MN 55440-1309 952-883-6000
Network Providers:	Open Access Network
Contributions:	Please refer to the most recent enrollment material for information regarding contributions to your Plan which is hereby incorporated by this reference.