



Summary Plan Description

*Independent School District #318
(Grand Rapids Public Schools)
Employee Health Plan*

HealthPartners Open Access Choice

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Summary Plan Description Effective Date: The later of October 1, 2018 and the Covered Person's effective date of coverage under the Plan.

It is important that you read this entire Summary Plan Description (SPD) carefully. It explains the Plan, eligibility, notification procedures, covered expenses and expenses that are not covered.

This plan is a self-insured medical plan. HealthPartners is the claims administrator and provides administrative services only. This plan is not subject to ERISA.

HealthPartners Open Access Choice Schedule of Payments

See Sections III. and IV. of this SPD for additional information about covered services and limitations.

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

Coverage may vary according to your network or provider selection.

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

NOTE: Eligible Out-of-Network Provider services are limited to the usual and customary charge (see definition of "Charge").

If you have questions about your coverage, please call Member Services between 7 a.m. to 7 p.m., Monday through Friday at 800-883-2177 (toll free). You can also log onto your "myHealthPartners" account at www.healthpartners.com to find more information about your coverage.

Network Benefits and Out-of-Network Benefits

Network Individual Calendar Year Out-of-Pocket Limit	\$7,350
Network Family Calendar Year Out-of-Pocket Limit	\$14,700
Out-of-Network Individual Calendar Year Out-of-Pocket Limit	None.
Out-of-Network Family Calendar Year Out-of-Pocket Limit	None.

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

Charges for Out-of-Network providers that are in excess of the usual and customary charge are the responsibility of the Covered Person.

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

Network Benefits and Out-of-Network Benefits

Network Individual Calendar Year Deductible for Prescription Drugs	\$1,100
Out-of-Network Individual Calendar Year Deductible for Prescription Drugs	\$1,100
Network Individual Calendar Year Deductible for Prescription Drugs	\$1,100
Out-of-Network Individual Calendar Year Deductible for Prescription Drugs	\$1,100

The deductibles for prescription drugs under the Network Benefits and Out-of-Network Benefits are separate.

*There may be limitations to the benefits.
Please see Section III. and IV. for more detail.*

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

Network Benefits and Out-of-Network Benefits

Charges for Out-of-Network providers that are in excess of the usual and customary charge are the responsibility of the Covered Person.

YOU MAY BE REQUIRED TO GET PRE-CERTIFICATION BEFORE USING CERTAIN OUT-OF-NETWORK SERVICES. SEE SECTION I, SUBSECTION F. "CARECHECK®" IN THIS SPD FOR SPECIFIC INFORMATION ABOUT PRE-CERTIFICATION.

- A. ACUPUNCTURE** \$10 copayment and 100% thereafter per office visit.
- B. AMBULANCE AND MEDICAL TRANSPORTATION** 80% of the charges incurred.
- C. AUTISM TREATMENT** \$10 copayment and 100% thereafter per office visit for Network Benefits.
The Plan covers Applied Behavioral Analysis (ABA), Intensive Early Intervention Behavioral Therapy (IEIBT), and Lovaas for children diagnosed with autism spectrum disorders.
For services provided by Out-of-Network Providers:
No coverage.

D. BEHAVIORAL HEALTH SERVICES

Mental Health Services

- a. Outpatient Services, including family therapy and Group Therapy \$10 copayment and 100% thereafter per office visit.
For family therapy received, only one copayment will be charged, regardless of the number of family members primarily involved in the therapy.
- b. Inpatient Services, including day treatment services and psychiatric treatment for emotionally disabled children 100% of the charges incurred.

Chemical Health Services

- a. Outpatient Services, including group therapy \$10 copayment and 100% thereafter per office visit.
For family therapy received, only one copayment will be charged, regardless of the number of family members primarily involved in the therapy.
The Plan covers supervised lodging at a contracted organization for Covered Persons actively involved in an affiliated licensed chemical dependency day treatment or intensive outpatient program for treatment of alcohol or drug abuse.
- b. Inpatient Services, including day treatment services 100% of the charges incurred.

E. CHIROPRACTIC SERVICES

\$10 copayment and 100% thereafter per office visit.
Services provided by an Out-of-Network provider are limited to 15 visits per calendar year.

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

Network Benefits and Out-of-Network Benefits

Charges for Out-of-Network providers that are in excess of the usual and customary charge are the responsibility of the Covered Person.

F. CLINICAL TRIALS

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.

G. DENTAL SERVICES

DENTAL SERVICES UNDER THIS PLAN GENERALLY DO NOT INCLUDE DENTAL PROCEDURES OR TREATMENTS WHICH NORMALLY COULD BE PERFORMED IN YOUR DENTIST'S OFFICE INCLUDING ROUTINE CLEANINGS AND FILLINGS. BE SURE TO READ THE DESCRIPTION OF COVERAGE IN SECTION III.

Accidental Dental Services

\$10 copayment and 100% thereafter per office visit.

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

a. Medically Necessary Outpatient Dental Services

\$10 copayment and 100% thereafter per office visit.

b. Medically Necessary Hospitalization and Anesthesia for Dental Care

100% of the charges incurred.

c. Medical Complications of Dental Care

\$10 copayment and 100% thereafter per office visit.

Oral Surgery

\$10 copayment and 100% thereafter per office visit.

Special Oral Surgery

\$10 copayment and 100% thereafter per office visit.

Orthognathic Surgery Benefit

100% of the charges incurred.

Treatment of Cleft Lip and Cleft Palate of a Dependent Child

\$10 copayment and 100% thereafter per office visit.

Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD)

\$10 copayment and 100% thereafter per office visit.

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

Network Benefits and Out-of-Network Benefits

Charges for Out-of-Network providers that are in excess of the usual and customary charge are the responsibility of the Covered Person.

H. DIAGNOSTIC IMAGING SERVICES

(Including Outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT))

The Plan covers services provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)

Associated with covered preventive services (MRI/CT procedures are not considered preventive) 100% of the charges incurred.

For illness or injury

- a. Outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) 100% of the charges incurred.
- b. All other outpatient diagnostic imaging services 100% of the charges incurred.

I. DURABLE MEDICAL EQUIPMENT, PROSTHETICS AND SUPPLIES

Disposable Diabetic Supplies 100% of the charges incurred.

Disposable diabetic supplies include, but are not limited to, test strips, insulin syringes and lancets. No more than a 93-day supply of diabetic supplies will be covered and dispensed at a time.

Special dietary treatment for Phenylketonuria (PKU) 100% of the charges incurred.

Oral amino acid based elemental formula if it meets our medical coverage criteria 100% of the charges incurred.

All other Durable Medical Equipment 100% of the charges incurred.

Wigs for hair loss resulting from alopecia areata are subject to \$350 maximum benefit per calendar year.

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

Network Benefits and Out-of-Network Benefits

Charges for Out-of-Network providers that are in excess of the usual and customary charge are the responsibility of the Covered Person.

J. EMERGENCY AND URGENTLY NEEDED CARE SERVICES

Urgently Needed care provided at clinics

\$10 copayment and 100% thereafter per office visit.

Emergency care in a hospital emergency room, including professional services of a physician

\$150 copayment and 100% thereafter per emergency room visit.

The emergency room facility copay is waived if you are admitted for the same condition within 24 hours and are hospitalized for a minimum of 24 hours.

Inpatient emergency care in a hospital

100% of the charges incurred.

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.

K. HEALTH EDUCATION FOR CHRONIC CONDITIONS

The plan covers education for preventive services and education for the management of chronic health problems such as early pregnancy education, nutrition education, breast self-examination, cholesterol education and instruction regarding medications provided by network providers.

For services provided by Network Providers:
\$10 copayment and 100% thereafter per office visit.

For services provided by Out-of-Network Providers:
No coverage.

L. HOME HEALTH SERVICES

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

100% of the charges incurred.

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

100% of the charges incurred.

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.

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.

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

Network Benefits and Out-of-Network Benefits

Charges for Out-of-Network providers that are in excess of the usual and customary charge are the responsibility of the Covered Person.

For all other services that meet the home health services requirements described in this 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.

Routine postnatal well child visits

100% of the charges incurred.

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

M. HOME HOSPICE SERVICES

For services provided by a Network Provider:
100% of the charges incurred.

For services provided by an Out-of-Network Provider:
No coverage.

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

N. HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Medical or Surgical Hospital Services

a. Inpatient Hospital Services

100% of the charges incurred.

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.

b. Outpatient Hospital, Ambulatory Care or Surgical Facility Services (to see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see the benefits under Diagnostic Imaging Services, Laboratory Services and Physical Therapy)

100% of the charges incurred.

Skilled Nursing Facility Care

100% of the charges incurred.

Limited to 120 day maximum per period of confinement.

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

Network Benefits and Out-of-Network Benefits

Charges for Out-of-Network providers that are in excess of the usual and customary charge are the responsibility of the Covered Person.

O. INFERTILITY SERVICES

\$10 copayment and 100% thereafter per office visit.

Coverage is limited to office visits and consultations to diagnose infertility. Treatment is not covered.

P. LABORATORY SERVICES

The Plan covers services provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)

Associated with covered preventive services

100% of the charges incurred.

For illness or injury

100% of the charges incurred.

Q. MASTECTOMY RECONSTRUCTION BENEFIT

Coverage level is same as corresponding benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

R. OFFICE VISITS FOR ILLNESS OR INJURY

Office visits

\$10 copayment and 100% thereafter per office visit.

Convenience clinics

\$10 copayment and 100% thereafter per office visit.

Scheduled telephone visits

\$10 copayment and 100% thereafter per visit.

E-visits

Access to Online Care through virtuwel at www.virtuwel.com

The first three visits to virtuwel in a calendar year are paid at 100%. Then all virtuwel services will be covered at 100% of the charges incurred, subject to a copayment of \$10 per visit.

All other E-visits

\$10 copayment and 100% thereafter per visit.

Injections administered in a physician's office

Allergy injections

100% of the charges incurred.

All other injections

100% of the charges incurred.

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

Network Benefits and Out-of-Network Benefits

Charges for Out-of-Network providers that are in excess of the usual and customary charge are the responsibility of the Covered Person.

S. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY

The Plan covers services provided in a clinic. The Plan also covers physical therapy provided in an outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)

Rehabilitative therapy

\$10 copayment and 100% thereafter per visit.

Physical and Occupational therapy services provided by an Out-of-Network provider are limited to 15 visits, combined, per calendar year.

Speech therapy services provided by an Out-of-Network provider are limited to 15 visits per calendar year.

T. PRE-DIABETES DISEASE MANAGEMENT PROGRAM

For services provided by a Network Provider:
100% of the charges incurred.

For services provided by an Out-of-Network Provider:
No coverage.

U. PRESCRIPTION DRUG SERVICES

Prescription drugs are subject to the calendar year deductibles shown below unless otherwise stated in this section.

Drugs and medications must be part of the formulary (the formulary is available online at www.healthpartners.com or by calling Member Services)

Network Individual Calendar Year Deductible For Prescription Drugs

\$1,100

Out-of-Network Individual Calendar Year Deductible For Prescription Drugs

\$1,100

Network Family Calendar Year Deductible For Prescription Drugs

\$1,100

Out-of-Network Family Calendar Year Deductible For Prescription Drugs

\$1,100

The deductibles for prescription drugs under the Network Benefits and Out-of-Network Benefits are separate.

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

Network Benefits and Out-of-Network Benefits

Charges for Out-of-Network providers that are in excess of the usual and customary charge are the responsibility of the Covered Person.

Formulary Drugs (except as specified below)

100% of the charges incurred per prescription.
Prescription Drug Deductible applies.

Formulary contraceptives are covered at 100% of the charges incurred.
Prescription Drug Deductible does not apply.

Drugs for breast cancer prevention are covered at 100% of the charges incurred for women at high risk for breast cancer who have not yet been diagnosed with the disease.
Prescription Drug deductible does not apply.

Formulary drugs for the treatment of sexual dysfunction are limited to six doses per month.

Diabetic Supplies purchased at a pharmacy

100% of the charges incurred.
Prescription Drug Deductible does not apply.

Tobacco cessation products, as determined by HealthPartners.

Must be prescribed by a licensed provider.

100% of the charges incurred per prescription.
Prescription Drug Deductible does not apply.

Tobacco cessation products **must** be obtained from a network pharmacy to be covered under this Plan.

Mail Order Drugs

For your convenience, you may also get outpatient formulary prescription drugs which can be self-administered through HealthPartners mail order service. See the Formulary Drugs Benefit above for drugs ordered through this service. The service may be used for each 93-day supply, or portion thereof.

Prescription Drug Deductible applies.

Drugs for the treatment of sexual dysfunction are limited to 18 doses per three month supply.

Specialty drugs are not available through the mail order service.

Specialty drugs which are self-administered

100% of the charges incurred per prescription.
Prescription Drug Deductible applies.

Drugs for the treatment of growth deficiency

100% of the charges incurred.
Prescription Drug Deductible applies.

Specialty drugs are limited to drugs on the specialty drug list, and must be obtained from a designated vendor.

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

Network Benefits and Out-of-Network Benefits

Charges for Out-of-Network providers that are in excess of the usual and customary charge are the responsibility of the Covered Person.

Unless otherwise specified above in the Prescription Drug Services section, you may receive up to a 34-day supply, per prescription. Certain drugs may require prior authorization as indicated on the formulary. The Plan may require prior authorization for the drug and also the site where the drug will be provided. All drugs are subject to HealthPartners utilization review process and quantity limits. New prescriptions to treat certain chronic conditions are limited to a 34-day supply. In addition, certain drugs may be subject to any quantity limits applied as part of the trial program. The trial drug program applies to new prescriptions for certain drugs which have high toxicity, low tolerance, high costs and/or high potential for waste. Trial drugs are indicated on the formulary and/or the specialty drug list. Your first fill of a trial drug may be limited to less than a month supply. If the drug is well tolerated and effective, you will receive the remainder of your first month supply. Certain non-formulary drugs require prior authorization. If a prescription is for an 93-day supply, it must be filled at a pharmacy that participates in the HealthPartners extended day supply program. No more than a 34-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 34-day supply.

Drugs on the Excluded Drug List are not covered. The Excluded Drug List includes select drugs within a therapy class that are not eligible for coverage. You can find the Excluded Drug List if you go to healthpartners.com, select Pharmacy and select any of the formularies.

V. PREVENTIVE SERVICES

- | | |
|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| 1. Routine health exams and periodic health assessments | 100% of the charges incurred. |
| 2. Child Health Supervision Services | 100% of the charges incurred.

Covers dependents to age six and appropriate immunizations to age 19. |
| 3. Routine prenatal care | 100% of the charges incurred. |
| 4. Routine postnatal care | 100% of the charges incurred. |
| 5. Routine screening procedures for cancer | |
| Cancer screening with standard adult health examination | 100% of the charges incurred. |
| Cancer screening without standard adult health examination | 100% of the charges incurred. |
| 6. Routine eye and hearing exams | 100% of the charges incurred.

<i>Eye exams are limited to one exam per person per calendar year.</i> |
| 7. Professional voluntary family planning services | 100% of the charges incurred. |
| 8. Adult immunizations | 100% of the charges incurred. |

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

Network Benefits and Out-of-Network Benefits

Charges for Out-of-Network providers that are in excess of the usual and customary charge are the responsibility of the Covered Person.

- 9. Women’s preventive health services including all FDA approved contraceptive methods as prescribed by a physician (see prescription drug services section for coverage of contraceptive drugs)**

100% of the charges incurred.

- 10. Obesity screening and management**

100% of the charges incurred.

W. SPECIFIED OUT-OF-NETWORK SERVICES

Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as office visits for illness or injury for the following services only:

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

X. TELEMEDICINE BENEFIT

For services provided by a Network Provider:
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.

For services provided by an Out-of-Network Provider:
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.

Y. TRANSPLANT SERVICES

100% of the charges incurred for transplants provided in a network transplant center.

There is no coverage if you use an Out-of-Network transplant center.

Z. WEIGHT LOSS SURGERY OR BARIATRIC SURGERY

For services provided by a Network Provider:
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.

For services provided by an Out-of-Network Provider:
No coverage.

Specific Information About The Plan

Employer:	Independent School District #318 (Grand Rapids Public Schools)
Name of the Plan:	The Plan shall be known as the Independent School District #318 (Grand Rapids Public Schools), Employee Health Plan which provides employee and dependent medical benefits
Address of the Plan:	820 NW First Avenue Grand Rapids, MN 55744-2701 218-327-5710
Group Number:	21666
Plan Year:	The period beginning on each October 1 in which the provisions of the Plan are in effect.
Plan Fiscal Year Ends:	September 30
Plan Sponsor: (is ultimately responsible for the management of the Plan; may employ or contract with persons or firms to perform day-to-day functions such as processing claims and performing other Plan-connected services.)	The Fringe Benefit Committee, Independent School District #318 (Grand Rapids Public Schools)
Agent for Service of Legal Process:	General Counsel for Independent School District #318 (Grand Rapids Public Schools)
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.)	The Fringe Benefit Committee, Independent School District #318 (Grand Rapids Public Schools)
Funding:	Claims under the Plan are paid from the assets of a trust of the Employees.
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:	This Plan is a self-insured medical plan funded by contributions from the Employer and/or Employees. The contributions toward the cost of your coverage under the Plan are determined by your bargaining unit agreement.

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) which is a related organization of HealthPartners, Inc.

HealthPartners, Inc. ("HealthPartners"). HealthPartners is a Minnesota non-profit corporation and managed care organization.

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

Powers of the Plan Sponsor. The Plan Sponsor shall have all powers and discretion necessary to administer the Plan, including, without limitation, powers to: (1) interpret the provisions of the Plan; (2) establish and revise the method of accounting for the Plan; (3) establish rules and prescribe any forms required for administration of the Plan; (4) change the Plan; and (5) 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 maximums, benefits payable and any other terms or conditions of the Plan. The Plan Sponsor's decision to change the Plan may be due to changes in applicable laws or for any other reason. The Plan may be changed to transfer the Plan's liabilities to another plan or split the Plan into two or more parts.

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

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.

RESPONSIBILITIES OF COVERED PERSONS

1. Read this SPD and the enrollment materials completely and comply with the stated rules and limitations.
2. Contact providers to arrange for necessary medical appointments.
3. Pay any applicable copayments, deductibles and contributions as stated in this SPD.
4. 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.

I. INTRODUCTION TO THE SUMMARY PLAN DESCRIPTION

A. SUMMARY PLAN DESCRIPTION ("SPD")

This SPD, along with the Plan Manager's medical coverage criteria (available by logging onto your "myHealthPartners" account at www.healthpartners.com or by calling Member Services), is your description of the Employer's Medical Benefit Plan ("the Plan"). It describes the Plan's benefits and limitations. Included in this SPD is a Schedule of Payments which states the amount payable for the covered services. Amendments which we include with this SPD or send you at a later date are fully made a part of this SPD.

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

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

B. 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.

C. 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.

D. 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.

E. 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.

Designated Physician, Provider, Facility or Vendor. This is a current list of network physicians, providers, facilities or vendors which are authorized to provide certain covered services as described in this SPD. Call Member Services or check on-line by logging onto your “myHealthPartners” account at www.healthpartners.com for a current list.

Network Providers. This is a current listing of participating licensed physicians, dentists, mental and chemical health or other health care providers, facilities and pharmacies that are authorized to provide certain covered services as described in the SPD. Call Member Services or visit www.healthpartners.com for a current directory of network providers that have entered into an agreement to provide health care services to Covered Persons.

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

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

ABOUT THE NETWORK

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

Network. This is the network of participating network providers.

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

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

Conditions that qualify for this benefit are:

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

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

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

Your physician may be required to obtain prior authorization for certain services. Your physician will coordinate the authorization process for any services which must first be authorized. You may call the Member Services Department or check on-line by logging onto your “myHealthPartners” account at www.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.

Your physician will obtain an authorization for (1) residential care for the treatment of eating disorders as an alternative to inpatient care in a licensed facility when medically necessary; (2) psychiatric residential treatment for emotionally disabled children; and (3) mental health services provided in the home.

You must use a designated convenience care clinic to obtain the convenience care benefit. You may call the Member Services Department or check on-line by logging onto your “myHealthPartners” account at www.healthpartners.com for a list.

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

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

To receive Network Benefits, weight loss surgery must be provided by a designated physician.

Multidisciplinary pain management must be provided at designated facilities.

Psychiatric residential treatment for emotionally disabled children must be provided at designated facilities.

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

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

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

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

F. NOTIFICATION/PRE-CERTIFICATION (CARECHECK[®])

If you use an Out-of-Network provider, you are responsible for notifying CareCheck[®]. Failure to follow CareCheck[®] procedures may result in a reduction of the maximum coverage available to you under the Plan. You may designate another person to contact CareCheck[®] for you. It is your responsibility to notify CareCheck[®] of all services requiring review as shown in 1. below.

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

2. Procedure To Follow To Receive Maximum Benefits

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

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

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

5. Information Needed When You Call CareCheck[®].

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

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

6. Pre-certification Process.

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

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

How to contact CareCheck[®]: You may call **952-883-6400** in the Minneapolis/St. Paul metro area, or **800-316-9807** (toll-free) outside the metro area, from 8:00 a.m. to 5:00 p.m. (Central Time) weekdays.

You can leave a recorded message at other times. You may also write CareCheck[®] at Quality Utilization Management Department, 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

G. ELIGIBILITY, EFFECTIVE DATE, LATE ENROLLMENT, SPECIAL ENROLLMENT PERIOD, MINIMUM PARTICIPATION CLAUSE, SPECIAL RULES RELATING TO MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM ("CHIP"), NEWBORN ENROLLMENT, CHANGES IN BENEFITS AND TERMINATION

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

- a. All employees, as determined by the Plan Sponsor (see below), working 10.5 hours per week and who are actively at work, are eligible for coverage on the date of hire, rehire or date of transfer or job position change. 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.

If application is made more than 31 days after the date of eligibility, you may be considered to be a late entrant. 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.

- 1) Hired as a new certified administrator regardless of past job history in the district
- 2) Hired as a new district building employee regardless of past job history in the district.
- 3) Hired as a new production, construction, and maintenance employee regardless of past job history in the district.
- 4) Hired as a new teacher regardless of past job history in the district.
- 5) Transferring from a bargaining unit with no contribution to a bargaining unit with contribution.
- 6) Adding a job position from a bargaining unit with contribution after having waived membership while in a different bargaining unit with no contribution.
- 7) Obtained a job promotion within a bargaining unit that enables the employee who received no contribution per contract to now receive contribution.
- 8) Non-bargaining unit employees who have waived participation, who subsequently obtain a job or job change that qualifies them for membership in a bargaining unit that provide a contribution.
- 9) If coverage under this Plan terminated due to you being placed on unrequested leave, and you return to active service, coverage will become effective on the date you return to active service, provided you enroll within 31 days of return to active service. With respect to the Pre-Existing Condition Limitation, you will be reinstated to the same status that was in effect at the time of termination of coverage.
- 10) Employees who are on board-approved leave, who prior to the leave were covered under the Plan.

- b. All early retirees and retirees as defined by the Plan Sponsor.
- c. For all other individuals who are not active employees and who are eligible for Medicare (parts A and B), you must be enrolled in both Medicare parts A and B in order to be eligible for the Plan.

In general, to be eligible for Medicare, a person would be age 65 or older, disabled under age 65, and people of all ages with End Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

Individual circumstances may vary. For more detailed information on Medicare eligibility, please visit www.medicare.gov or call 1-800-MEDICARE.

2. **EFFECTIVE DATE.** The employee and any dependent's effective date is the date of hire.

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

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

3. **LATE ENROLLMENT.** If you are a late enrollee, you may 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.

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

- a. 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;
- b. 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;
- c. the employee's or dependent's coverage described in a. above was:
 - (1) under a COBRA continuation provision and the coverage under such provision was exhausted; or
 - (2) 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
- d. the employee requested such enrollment not later than 31 days after the date of exhaustion of coverage described in c. (1) above, or one of the events listed in c. (2) 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:

- a. the date dependent coverage is made available; or
- b. 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:

- a. 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;
- b. in the case of a dependent's birth, as of the date of such birth; or
- c. in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

5. MINIMUM PARTICIPATION CLAUSE. If a new employee or late entrant enrolls in the Plan, they are required to participate for a minimum of six (6) months at the coverage in place at the time of enrollment. If the employee reduces or drops coverage, the employee will continue to be charged for the original coverage requested until they reach their six month anniversary of enrolling. Reductions in coverage taking place with less than six (6) months of coverage in place will be allowed under the following circumstances:

- a. The employee marries or divorces.
- b. The employee's Covered Dependent(s) dies.
- c. The employee loses coverage under the Plan or experiences a reduction in district contribution due to an involuntary employment change.

6. 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:

- a. Termination of Medicaid or CHIP Coverage – the employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a state child health plan under title XXI of such Act and coverage of the employee or dependent under such plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the Plan not later than 60 days after the date; or
- b. 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.

7. NEWBORN ENROLLMENT. The Plan Administrator requests that you submit written application to add your newborn child or newborn grandchild within 90 days of the date of birth. An adopted child must be added within 90 days of the date of placement.

8. 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.

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

- a. The contribution for coverage under the Plan is not made by the due date.
- b. 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 section VII.A.

- c. When a Covered Dependent no longer meets this Plan's definition of eligible dependent, coverage for that dependent terminates the last day of the month in which the dependent's eligibility ceases, unless group continuation is elected as described in section VII.A.
- d. When the maximum period under the group continuation coverage described in section VII.A expires for a Covered Person.
- e. When the Plan terminates.
- f. 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 Summary Plan Description or disenroll the Covered Person.

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

H. 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.

II. DEFINITIONS OF TERMS USED

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

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

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

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.

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

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

Charge. For covered services delivered by participating network providers, this is the provider's discounted charge for a given medical/surgical service, procedure or item.

For covered services delivered by out-of-network providers, a contracted rate may apply if such arrangement is available to the Plan Manager.

For the usual and customary charge for covered services delivered by out-of-network providers, the Plan's payment is calculated using one of the following options to be determined at the Plan Manager's discretion: 1) a percentage of the Medicare fee schedule; 2) a comparable schedule if the service is not available on the Medicare fee schedule; or 3) a commercially reasonable rate for such service.

The usual and customary charge is the maximum amount allowed that the Plan considers in the calculation of the payment of charges incurred for certain covered services. You must pay for any charges above the usual and customary charge, and they do not apply to the out-of-pocket limit.

A charge is incurred for covered ambulatory medical and surgical services on the date the service or item is provided. A charge is incurred for covered inpatient services 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.

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

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

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.

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

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

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

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

Covered Service. This is a specific medical or dental service or item, which is medically necessary or dentally necessary and covered by the Plan, as specifically 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.

Deductible for Outpatient Prescription Drugs Only. The specified dollar amount of charges incurred for covered outpatient prescription drugs, 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 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' charges or the usual and customary charge for a service.

Amounts paid or reimbursed by a third party, including but not limited to: point of service rebates, manufacturer coupons, debit cards or other forms of direct reimbursement to a Covered Person for a product or service, may not apply toward your deductible.

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

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

Eligible Dependents. These are the persons shown below. 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.

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

1. **Spouse.** This is a Covered Employee's current legal spouse. If more than one spouse is covered as an employee under the Plan, only one spouse shall be considered to have any eligible dependents.
2. **Child.** This is a Covered Employee's (a) natural or legally adopted child (effective from the date of adoption or the date placed for adoption, whichever is earlier); (b) child for whom the Covered Employee or the Covered Employee's spouse is the legal guardian; (c) step-child of the Covered Employee (that is, the child of the Covered Employee's spouse); or (d) a child covered under a valid qualified medical child support order (as the term is defined by applicable law) which is enforceable against a Covered Employee. (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.) In each case the child must be either under 26 years of age or a disabled dependent, as described below. Coverage will terminate the end of the month in which the child turns age 26.
3. **Grandchild.** This is a grandchild of a Covered Employee or a Covered Employee's spouse who is financially dependent on the covered grandparent. The grandchild must be either under 26 years of age or a disabled dependent, as described below. Coverage will terminate the end of the month in which the dependent grandchild turns age 26.
4. **Disabled Dependent.** This is a Covered Employee's dependent as referred to in 2. and 3. above, who is beyond the limiting age and is physically or mentally disabled, and dependent on the Covered Employee for the majority of his/her financial support. The disability must have come into existence prior to the attainment of the limiting age as described in 2. and 3. above. Disability does not include pregnancy. "Disabled" means incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability. The Covered Employee must give the Plan Manager a written request for coverage of a disabled dependent. 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, or when adding a new disabled dependent eligible 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.

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

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

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

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

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

Formulary. This is a current list, which may be revised from time to time, of formulary prescription drugs, medications, equipment and supplies covered under the Plan as indicated in the Schedule of Payments which are covered at the highest benefit level. Some drugs may require prior authorization to be covered as formulary drugs. HealthPartners also has written guidelines and procedures for granting an exception to the formulary that is available to you upon request. These guidelines and procedures include exceptions to the formulary for anti-psychotic drugs prescribed to treat emotional disturbances or mental illness if your health care provider (1) indicates to the dispensing pharmacist, orally or in writing, that the prescription must be dispensed as indicated and (2) certifies in writing to HealthPartners that the prescribed drug will best treat your condition. Also, you may continue to receive certain non-formulary drugs for diagnosed mental illness or emotional disturbance when the formulary changes or you change health plans for up to one year following the change. The formulary, and information on drugs that require prior authorization, are available by logging onto your “myHealthPartners” account at www.healthpartners.com or by calling Member Services.

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

Habilitative Care. This is health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

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

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

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

Investigative. As determined by HealthPartners, a drug, device or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness or effect on health outcomes. The following categories of reliable evidence will be considered, none of which shall be determinative by itself:

1. Whether 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 U.S. Food and Drug Administration (FDA); if the drug or device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials; or if the drug, device or medical treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and
2. Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether a drug is included in the American Hospital Formulary Service as appropriate for its proposed use; and
3. Whether there are consensus opinions of national and local health care providers in the applicable specialty as determined by a sampling of providers, including whether there are protocols used by the treating facility or another facility studying the same drug, device, medical treatment or procedure.

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.

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/Medically Necessary Care. This is health care services 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:

1. Appropriate for the symptoms, diagnosis or treatment of your medical condition;
2. Consistent with evidence-based standards of medical practice where applicable;
3. Not primarily for your convenience or that of your family, your physician, or any other person; and
4. The most appropriate and cost-effective level of medical services 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.

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

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

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

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

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

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

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

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).

Period of Confinement. This is (1) one continuous hospitalization, or (2) a series of hospitalizations or skilled nursing facility stays, or periods of time when the Covered Person is receiving home health services, for the same medical condition in which the end of one is separated from the beginning of the next by less than 90 days. For the purpose of this definition, "same condition" means illness or injury related to former illness or injury in that it is either within the same ascertainable diagnosis or set of diagnoses, or within the scope of complications or related conditions.

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

Prescription Drug. This is any medical substance for the prevention, diagnosis or treatment of injury, disease or illness approved and/or regulated by the U.S. 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.

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

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

Rehabilitative Care. This is health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

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

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

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

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

III. DESCRIPTION OF COVERED SERVICES

The Plan covers the services described below and on the Schedule of Payments. The Schedule of Payments describes the level of payment that applies for each of the covered services. To be covered under this section, the medical or dental services or items described below must be medically necessary or dentally necessary.

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

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. Covered prescription drugs are based on requirements established by the HealthPartners Pharmacy and Therapeutics Committee, and are subject to periodic review and modification. These medical policies (medical coverage criteria) and formulary requirements are available by logging onto your “myHealthPartners” account at www.healthpartners.com or by calling Member Services at 952-883-5000.

A. ACUPUNCTURE

The Plan covers acupuncture services when medically necessary.

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. These medical policies (medical coverage criteria) are available by logging onto your “myHealthPartners” account at www.healthpartners.com or by calling Member Services.

B. AMBULANCE AND MEDICAL TRANSPORTATION

The Plan covers certain ambulance and medical transportation for medical emergencies and medically necessary, non-emergency medical transportation if it meets HealthPartners medical coverage criteria.

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. These medical policies (medical coverage criteria) and applicable prior authorization requirements are available by logging onto your “myHealthPartners” account at www.healthpartners.com or by calling Member Services.

C. AUTISM TREATMENT

The Plan covers Applied Behavioral Analysis (ABA), Intensive Early Intervention Behavioral Therapy (IEIBT), and Lovaas for children to age 18. For other autism services covered under the Plan, see the rehabilitative therapy benefit under Physical Therapy, Occupational Therapy and Speech Therapy section.

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. These medical policies (medical coverage criteria) are available by logging onto your “myHealthPartners” account at www.healthpartners.com or by calling Member Services.

D. BEHAVIORAL HEALTH SERVICES

1. Mental Health Services

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

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

- a. **Outpatient 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 made of each patient as the basis for a determination by a mental health professional, concerning the appropriate treatment and the extent of services required.

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

- (1) Individual, group, family, and multi-family therapy;
- (2) Medication management provided by a physician, certified nurse practitioner, or physician's assistant;
- (3) Psychological testing services for the purposes of determining the differential diagnoses and treatment planning for patients currently receiving behavioral health services;
- (4) Psychotherapy and nursing services provided in the home if authorized by HealthPartners; and
- (5) Treatment for gender dysphoria that meets medical coverage criteria.

- b. **Inpatient Services (including day treatment services).** The Plan covers medically necessary inpatient services in a hospital and professional services for treatment of mental health disorders. Medical stabilization is covered under inpatient hospital services in the “Hospital and Skilled Nursing Facility Services” section.

The Plan also covers day treatment and partial hospitalization services in a hospital or licensed psychiatric residential treatment facility and professional services for treatment of eating disorders.

The Plan also covers medically necessary psychiatric residential treatment for emotionally disabled children as diagnosed by a physician. This care must be authorized by HealthPartners and provided by a hospital or residential treatment center licensed by the local state or Department of Health and Human Services. The child must be under 18 years of age and an eligible dependent according to the terms of this SPD. Services not covered under this benefit include shelter services, correctional services, detention services, transitional services, group residential services, foster care services and wilderness programs.

2. Chemical Health Services

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

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

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

- (1) Individual, group, family, and multi-family therapy provided in an office setting; and
- (2) Opiate replacement therapy including methadone and buprenorphine treatment.

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

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

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

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. These medical policies (medical coverage criteria) are available by logging onto your “myHealthPartners” account at www.healthpartners.com or by calling Member Services.

E. CHIROPRACTIC SERVICES

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

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

F. CLINICAL TRIALS

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

G. DENTAL SERVICES

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

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

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

2. Medical Referral Dental Services.

- a. 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.
 - b. Medically Necessary Hospitalization and Anesthesia for Dental Care.** The Plan covers certain medically necessary hospitalization and anesthesia for dental care. This is limited to charges incurred by a Covered Person who: (1) is a child under age five; (2) is severely disabled; (3) has a medical condition, and requires hospitalization or general anesthesia for dental care treatment; (4) is a child between age five and 12 and care in dental offices has been attempted unsuccessfully and usual methods of behavior modification have not been successful; or (5) when extensive amounts of restorative care, exceeding four appointments, are required. Coverage is limited to facility and anesthesia charges. Anesthesia is covered in a hospital or a dental office. Oral surgeon/dentist professional fees are not covered. The following are examples, though not all-inclusive, of medical conditions which may require hospitalization for dental services: severe asthma, severe airway obstruction or hemophilia. Except as listed above, hospitalization required due to the behavior of the Covered Person or due to the extent of the dental procedure is not covered.
 - c. 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.
- 3. 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.
 - 4. Special Oral Surgery.** In addition, the following services are available, as indicated in the Schedule of Payments: oral surgery for (1) partially or completely unerupted impacted teeth; (2) a tooth root without the extraction of the entire tooth (this does not include root canal therapy); and (3) the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.
 - 5. Orthognathic Surgery Benefit.** The Plan covers orthognathic surgery for the treatment of severe skeletal dysmorphia where a functional occlusion cannot be achieved through non-surgical treatment alone and where a demonstrable functional impairment exists. Functional impairments include but are not limited to significant impairment in chewing, breathing or swallowing. Associated dental or orthodontic services (pre or post operatively including surgical rapid palatal expansion) are not covered as a part of this benefit.
 - 6. Treatment of Cleft Lip and Cleft Palate.** The Plan covers certain treatment of cleft lip and cleft palate of a dependent child, to the limiting age in the definition of an “Eligible Dependent”, including orthodontic treatment and oral surgery directly related to the cleft. Benefits for individuals up to age 26 for coverage of the dependent are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. Dental services which are not necessary for the treatment of cleft lip or cleft palate are not covered. If a dependent child covered under the Plan is also covered under a dental plan which

includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same copayment, conditions and limitations as durable medical equipment.

7. **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.

H. DIAGNOSTIC IMAGING SERVICES

The Plan covers diagnostic imaging, when ordered by a provider and provided in a clinic or outpatient hospital facility.

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

I. DURABLE MEDICAL EQUIPMENT, PROSTHETICS AND SUPPLIES

The Plan covers equipment and services, as described below.

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

Diabetic supplies and equipment are limited to certain models and brands.

We cover special dietary treatment for Phenylketonuria (PKU) and oral amino acid based elemental formula if it meets our medical coverage criteria.

External hearing aids (including osseointegrated or bone anchored) for Covered Persons to age 19 or younger who have hearing loss that is not correctable by other covered procedures. Coverage is limited to one hearing aid for each ear every three years.

2. Coverage of durable medical equipment is limited by the following:
 - a. Payment will not exceed the cost of an alternate piece of equipment or service that is effective and medically necessary.
 - b. For prosthetic benefits, other than hair prostheses (i.e. wigs) for hair loss resulting from alopecia areata and oral appliances for cleft lip and cleft palate, payment will not exceed the cost of an alternate piece of equipment or service that is effective and medically necessary and enables Covered Persons to conduct standard activities of daily living.
 - c. The Plan reserves the right to determine if an item will be approved for rental vs. purchase.
3. Items which are not eligible for coverage include, but are not limited to:
 - a. Replacement or repair of any covered items, if the items are: (1) damaged or destroyed by misuse, abuse or carelessness; (2) lost; or (3) stolen.
 - b. Duplicate or similar items.
 - c. Labor and related charges for repair of any covered items which are more than the cost of replacement by a designated vendor.
 - d. Sales tax, mailing, delivery charges, service call charges.
 - e. Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience or recreation.
 - f. Communication aids or devices: equipment to create, replace or augment communication abilities including, but not limited to, hearing aids (implantable and external, including osseointegrated or bone anchored), fitting of hearing aids, speech processors, receivers,

communication boards, or computer or electronic assisted communication, except as specifically described in this SPD. This exclusion does not apply to cochlear implants, which are covered as described in the medical coverage criteria. These medical policies (medical coverage criteria) are available by logging onto your “myHealthPartners” account at www.healthpartners.com or by calling Member Services.

- g. Household equipment which primarily has customary uses other than medical, such as, but not limited to, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds.
- h. Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools, whirlpools and saunas.
- i. Modifications to the structure of the home including, but not limited to, its wiring, plumbing or charges for installation of equipment.
- j. Vehicle, car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carriers.
- k. Rental equipment while the Covered Person's owned equipment is being repaired, beyond one month rental of medically necessary equipment.
- l. Other equipment and supplies, including but not limited to assistive devices, that the Plan Manager determines are not eligible for coverage.
- m. Foot orthotics, except custom molded foot orthotics ordered for individuals diagnosed with polio or diabetes with neurological manifestations and arthropathy and/or ulcer(s) of the lower limbs.

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

Covered services and supplies are based on established medical policies and the formulary, which are subject to periodic review and modification by the medical directors. Our coverage policy for diabetic supplies includes information on the required models and brands. These medical policies (medical coverage criteria) are available by logging onto your “myHealthPartners” account at www.healthpartners.com or by calling Member Services.

J. EMERGENCY AND URGENTLY NEEDED CARE SERVICES

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

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

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

K. HEALTH EDUCATION FOR CHRONIC CONDITIONS

The plan covers education for preventive services and education for the management of chronic health problems such as early pregnancy education, nutrition education, breast self-examination, cholesterol education and instruction regarding medications provided by network providers.

L. HOME HEALTH SERVICES

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

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

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

Home health services are eligible and covered only when they are:

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

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

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

M. HOME HOSPICE SERVICES

Applicable Definitions:

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

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

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

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

1. **Home Hospice Program.** The Plan covers the services described below for Covered Persons who are terminally ill patients and accepted as home hospice program participants. Covered Persons must meet the eligibility requirements of the program, and elect to receive services through the home hospice program. The services will be provided in the patient's home, with inpatient care available when medically necessary as described below. Covered Persons who elect to receive hospice services do so in lieu of curative treatment for their terminal illness for the period they are enrolled in the home hospice program.
 - a. **Eligibility:** In order to be eligible to be enrolled in the home hospice program, a Covered Person must: (1) be a terminally ill patient (prognosis of six months or less); (2) have chosen a palliative treatment focus (i.e., emphasizing comfort and supportive services rather

than treatment attempting to cure the disease or condition); and (3) continue to meet the terminally ill prognosis as determined by HealthPartners medical director or his or her designee over the course of care. A Covered Person may withdraw from the home hospice program at any time.

- b. **Eligible Services:** Hospice services include the following services provided by Medicare-certified providers, if provided in accordance with an approved hospice treatment plan.
 - (1) **Home Health Services:**
 - (a) 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.
 - (b) 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.
 - (2) **Inpatient Services:** The Plan covers medically necessary inpatient services.
 - (3) **Other Services:**
 - (a) 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.
 - (b) Medically necessary medications for pain and symptom management.
 - (c) Medically necessary semi-electric hospital beds and other durable medical equipment are covered.
 - (d) Medically necessary emergency and non-emergency care are covered.

- 2. **What Is Not Covered.** The Plan does not cover the following services:
 - a. financial or legal counseling services; or
 - b. housekeeping or meal services in the patient's home; or
 - c. custodial care related to hospice services, whether provided in the home or in a nursing home; or
 - d. any service not specifically described as a covered service under this home hospice services section; or
 - e. any services provided by a member of the patient's family or resident in the Covered Person's home.

N. HOSPITAL AND SKILLED NURSING FACILITY SERVICES

1. Medical or Surgical Hospital Services

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

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

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

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in

connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

Services or items for personal convenience, such as television rental, are not covered.

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

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

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

To see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see the benefits under Diagnostic Imaging Services, Laboratory Services and Physical Therapy in the Schedule of Payments.

2. **Skilled Nursing Facility Care.**

The Plan covers room and board, daily skilled nursing and related ancillary services for post-acute treatment and rehabilitative care of illness or injury that meets medical coverage criteria.

O. INFERTILITY 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.

P. LABORATORY SERVICES

The Plan covers medically necessary laboratory tests and preventive services as shown below under Preventive Services when ordered by a provider and provided in a clinic or outpatient hospital facility.

Q. MASTECTOMY RECONSTRUCTION BENEFIT

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, and prostheses and treatment for physical complications during all stages of mastectomy, including lymphedemas.

R. OFFICE VISITS FOR ILLNESS OR INJURY

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

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

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

S. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY

The Plan covers rehabilitative physical therapy, occupational therapy to correct the effects of illness or injury and the evaluation for the need for speech therapy.

Speech therapy services which are primarily educational in nature and provided for the purpose of correcting speech impediments or assisting in the initial development of verbal facility or clarity are not covered.

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

T. PRE-DIABETES DISEASE MANAGEMENT PROGRAM

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

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

Eligibility for participation in the program is based on established medical policies, which are subject to periodic review and modification by the medical directors. These medical policies (medical coverage criteria) are available by logging onto your “myHealthPartners” account at www.healthpartners.com or by calling Member Services.

U. PRESCRIPTION DRUG SERVICES

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

V. PREVENTIVE SERVICES

The Plan covers the following preventive services:

1. 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 the age, sex and health status of the Covered Person. This includes counseling for tobacco cessation.
2. Child health supervision services, including pediatric preventive services, routine immunizations, developmental assessments and laboratory services appropriate to the age of the child from birth to 72 months, and appropriate immunizations to age 19. This includes counseling for tobacco cessation.
3. Routine prenatal care and exams to include visit-specific screening tests, education and counseling.
4. Routine postnatal care and exams to include health exams, assessments, education and counseling relating to the period immediately after childbirth.
5. Routine screening procedures for cancer (and the standard adult health examination associated with cancer screening).

6. Routine eye and hearing exams.
7. Professional voluntary family planning services.
8. Adult immunizations.
9. Women's preventive health services; including mammograms, screenings for cervical cancer; breast pumps; human papillomavirus (HPV) testing; counseling for sexually transmitted infections; counseling and screening for human immunodeficiency virus (HIV); and FDA approved contraceptive methods, sterilization procedures, education and counseling.
10. Obesity screening and counseling is covered for all ages during a routine preventive care exam. If you are age 18 or older and have a body mass index of 30 or more, intensive obesity management is covered to help you lose weight. Your primary care physician can coordinate the services.

A list of preventive services that must be covered at the Network Benefit level at 100% is published by the federal government. Routine preventive services include recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and the Health Resources and Services Administration (HRSA). Covered services are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. These medical policies (medical coverage criteria) are available by logging onto your "myHealthPartners" account at www.healthpartners.com or by calling Member Services.

W. SPECIFIED OUT-OF-NETWORK SERVICES

The Plan covers the following services, when a Covered Person elects to receive them from an out-of-network provider, at the same level of coverage the Plan provides when a Covered Person elects to receive the services from a network provider:

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

X. TELEMEDICINE BENEFIT

The Plan covers telemedicine services that meet HealthPartners medical coverage criteria.

Y. TRANSPLANT SERVICES

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

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

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

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

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

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

Transplant Services. This is transplantation (including retransplants) of the human organs or tissue listed 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.

What is covered. 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:

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

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

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

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

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

Z. WEIGHT LOSS SURGERY OR BARIATRIC SURGERY

Covered services are based on established medical policies, which are subject to periodic review and modification by the medical directors. These medical policies (medical coverage criteria) are available by logging onto your "myHealthPartners" account at www.healthpartners.com or by calling Member Services.

IV. SERVICES NOT COVERED

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

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

17. Medical Food. Enteral feedings, unless they are the sole source of nutrition used to treat a life-threatening condition, nutritional supplements, over-the-counter electrolyte supplements and infant formula, except as specified in this SPD. This exclusion does not apply to oral amino acid based elemental formula or other items if they meet HealthPartners medical coverage criteria.
18. Charges for sales tax.
19. Services provided by a family member of the Covered Person, or a resident in the Covered Person's home.
20. Religious counseling, marital/relationship counseling and sex therapy.
21. Private duty nursing services.
22. 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.
23. The portion of a billed charge for an otherwise covered service by a provider, which is in excess of the usual and customary charges, or which is either a duplicate charge for a service or charges for a duplicate service.
24. Charges for services (a) for which a charge would not have been made in the absence of insurance or medical plan coverage, or (b) which the Covered Person is not legally obligated to pay, and (c) from providers who waive copayment, deductible and coinsurance payments by the Covered Person.
25. Travel and lodging incidental to travel, regardless if it is recommended by a physician and any travel billed by a provider.
26. Health club memberships.
27. Massage therapy for the purpose of a Covered Person's comfort or convenience.
28. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
29. Autopsies.
30. For Network Benefits, charges incurred for transplants, Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) received at facilities which are not designated facilities, or charges incurred for weight loss services provided by a physician who is not a designated physician.
31. Habilitative care.
32. Accident related dental services if treatment is (1) provided to teeth which are not sound and natural, (2) to teeth which have been restored, (3) initiated beyond six months from the date of the injury, (4) received beyond the initial treatment or restorations, or (5) received beyond 24 months from the date of injury.
33. Nonprescription (over-the-counter) drugs or medications, unless listed on the formulary and prescribed by a physician or legally authorized health care provider under applicable state law, including, but not limited to, vitamins, supplements, homeopathic remedies, and non-FDA approved drugs. This exclusion does not include over-the-counter contraceptives for women as allowed under the Affordable Care Act when the Covered Person obtains a prescription for the item.
34. Charges for elective home births.
35. Professional services associated with substance abuse intervention. A "substance abuse intervention" is a gathering of family and/or friends to encourage a person covered under this SPD to seek substance abuse treatment.
36. The portion of eligible services and supplies paid under Medicare.
37. Services or supplies that are primarily and customarily used for nonmedical purpose, or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment, air purifiers, air conditioners, dehumidifiers, heat/cold appliances, water purifiers, hypoallergenic mattresses, waterbeds, computers and related equipment, car seats, feeding chairs, pillows, food or weight scales, hot tubs, whirlpools, and incontinence pads or pants.
38. Modifications to home, vehicle, and/or the workplace, including vehicle lifts and ramps.
39. Personal comfort items, such as telephone, television, barber and beauty supplies, guest services, etc.
40. Charges for furnishing medical records or reports.
41. Services that are provided to you for the treatment of an employment-related injury for which you are entitled to make a workers' compensation claim.
42. Services for or related to gene therapy as a treatment for inherited or acquired disorders.
43. Services for or related to growth hormone, except that replacement therapy is eligible for conditions that meet medically necessary criteria as determined by the Claims Administrator prior to receipt of the services.
44. Services for or related to functional capacity evaluations for vocational purposes and/or determination of disability or pension benefits.
45. Foot orthotics, except custom molded foot orthotics ordered for individuals diagnosed with polio or diabetes with neurological manifestations and arthropathy and/or ulcer(s) of the lower limbs.

46. Court ordered treatment, except as described under “Mental Health Services” and “Office Visits for Illness and Injury” or as otherwise required by law.
47. Services provided by naturopathic providers.
48. Treatment, procedures, or services or drugs which are provided when you are not covered under this Plan.
49. Maintenance chiropractic therapy.
50. Care that is not rehabilitative in nature and medically necessary for the diagnosis and/or treatment of acute neuromusculoskeletal conditions.
51. Medication Therapy Disease Management consultation. This is a consultation with HealthPartners Network MTM pharmacists to review and manage high risk member medications.
52. 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.
53. Non-medical administrative fees and charges including, but not limited to, medical record preparation charges, appointment cancellation fees, after hours appointment charges, and interest charges.
54. Medical cannabis.
55. Drugs on the Excluded Drug List. The Excluded Drug List includes select drugs within a therapy class that are not eligible for coverage.

V. DISPUTES AND COMPLAINTS

A. 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; however, the Plan Sponsor will 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 established medical 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, you or your provider can discuss the decision with a clinician who reviewed the request for coverage. Call Member Services for assistance.

B. COMPLAINTS

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

Complaints must be made to:

HealthPartners

Member Services Department

8170 33rd Avenue South, P.O. Box 1309

Minneapolis, MN 55440-1309

Telephone: 952-883-5000 Outside the metro area: 800-883-2177 (toll-free)

VI. CONDITIONS

A. 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.

B. COORDINATION OF BENEFITS

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

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

1. Applicability.

- a. This Coordination of Benefits (COB) provision applies to the Plan when a Covered Employee or the Covered Employee's Covered Dependent has medical care coverage under more than one plan. "Plan" and "The Plan" are defined below.

- b. If this Coordination of Benefits provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of The Plan are determined before or after those of another plan. The benefits of The Plan:
 - (1) shall not be reduced when, under the order of benefit determination rules, benefits under The Plan are determined before another plan; but
 - (2) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in paragraph 4. below.

2. Definitions.

- a. **"Plan"** is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
 - (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.
- b. **"The Plan"** is the part of the Plan that provides benefits for medical care expenses.
- c. **"Primary Plan/Secondary Plan"** The order of benefit determination rules state whether The Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When The Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When The Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, The Plan may be a Primary Plan as to one or more of the plans and may be a Secondary Plan as to a different plan or plans.
- d. **"Allowable Expense"** is a necessary, reasonable and customary item of expense for medical care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a primary plan because a Covered Person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements.
- e. **"Claim Determination Period"** is a calendar year. However, it does not include any part of a year during which a person has no coverage under The Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

3. Order Of Benefit Determination Rules.

- a. **General.** When there is a basis for a claim under The Plan and another plan, The Plan is a Secondary Plan which has its benefits determined after those of another plan, unless:
 - (1) the other plan has rules coordinating its benefits with those of The Plan; and
 - (2) both those rules and The Plan's rules, in subparagraph b. below, require that The Plan's benefits be determined before those of the other plan.
- b. **Rules.** The order of benefits are determined using the first of the following rules which applies:
 - (1) Nondependent/Dependent. The benefits of the plan which cover the person as a Covered Person or subscriber (that is, other than as a dependent) are determined before those of the plan which cover the person as a dependent.

- (2) Dependent Child/Parents not Separated or Divorced. Except as stated in subparagraph b. (3) below, when The Plan and another plan cover the same child as a dependent of different persons, called "parents":
 - (a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
 - (b) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- (3) Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - (a) first, the plan of the parent with custody of the child;
 - (b) then, the plan of the spouse of the parent with the custody of the child; and
 - (c) finally, the plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the medical care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or calendar year during which any benefits are actually paid or provided before the entity has that actual knowledge.
- (4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for medical care expenses of the child, the plans covering the child follow the order of benefit determination rules outlined in subparagraph b. (2).
- (5) Active/Inactive Enrollee. The benefits of a plan which covers a person as a Covered Employee who is neither laid off nor retired (or as that Covered Employee's dependent) are determined before those of a plan which cover that person as a laid off or retired Covered Employee (or as that Covered Employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (6) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered a Covered Person or subscriber longer are determined before those of the plan which covered that person for the shorter term.

4. Effect On The Benefits Of This Plan.

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

Person and shall be used by the Secondary Plan to pay any allowable expenses, not otherwise paid, that are incurred by the Covered Person during the Claim Determination Period. As each claim is submitted, the Secondary Plan must:

- (1) determine its obligation, pursuant to the contract;
- (2) determine whether a benefit reserve has been recorded for the Covered Person; and
- (3) determine whether there are any unpaid allowable expenses during that Claim Determination Period.

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

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

The benefits provided by the Plan do not apply to injury or disease covered by no-fault insurance, employers liability laws (including workers' compensation), and care available or required to be furnished by or through national or state governments or their agencies including care to which a Covered Person is legally entitled and for which facilities are reasonably available for military service-connected conditions or disabilities. Subject to the Plan's rights in A. "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).

C. MEDICARE AND THE PLAN

All individuals who are not active employees and who are eligible for Medicare (parts A and B) must be enrolled in both Medicare (parts A and B) in order to be eligible for 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:

1. 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.
2. 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.

Benefits will not be reduced under the Plan due to the Covered Person's eligibility for Medicare when federal law requires that the Plan determine benefits without regard to the benefits available under Medicare.

VII. CONTINUATION OF GROUP COVERAGE

If your eligibility for group coverage under the Plan ends because of one of the qualifying events shown below, you may be eligible to continue group coverage as shown below.

A. CONTINUATION OF GROUP COVERAGE

1. **Qualifying Events.** Coverage under the Plan may be continued by a Covered Employee, Covered Dependent spouse and other Covered Dependents, enrolled at the time coverage would otherwise end, or a child born to or placed for adoption with the Covered Employee during the period of continuation coverage, as a result of one of the following qualifying events:
 - a. Voluntary or involuntary termination of employment (except for gross misconduct) of the Covered Employee, or layoff from employment, or reduction in hours resulting in a loss of group coverage.
 - b. Death of the Covered Employee.
 - c. Divorce or legal separation of the Covered Employee.
 - 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.

a. **Maximum period**

- (1) **Termination and reduced hours.** The maximum period of continuation coverage is 18 months. If a second qualifying event, other than the Employer's bankruptcy, occurs during the 18 months, the maximum period of continuation coverage is 36 months. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".
- (2) **Disabled Covered Employee, Covered Dependent Spouse or Covered Dependent Child.** If the Covered Employee, Covered Dependent spouse or other Covered Dependent is disabled under Title II or XVI of the Social Security Act, at any time during the first 60 days of continuation of coverage, the 18-month maximum continuation period may be extended to 29 months. The disabled person must notify the Plan Sponsor within 60 days of the date of determination of disability, and within the initial 18-month continuation period. If a second qualifying event (other than bankruptcy) occurs during the extended 29-month period, the maximum period of continuation coverage is 36 months. See B. "Disabled Employee" below, which describes your rights for coverage as a disabled employee under Minnesota law.
- (3) **Bankruptcy.** In the case of bankruptcy of a retired Covered Employee's former Employer, the maximum period of continuation coverage is until the death of the retired Covered Employee. In the case of the surviving spouse or dependent children of the retired Covered Employee, the maximum period of continuation coverage is 36 months after the death of the retired Covered Employee.
- (4) **Divorce or legal separation.** Under Minnesota law, there is no maximum period of coverage for a former spouse or dependents who lose coverage due to divorce or legal separation. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".
- (5) **Death of Covered Employee.** Under Minnesota law, there is no maximum period of coverage for a surviving spouse and dependents who lose coverage due to the death of the Covered Employee. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".
- (6) **Other qualifying events.** The maximum period of continuation coverage for all other qualifying events is 36 months.

b. **Earlier Termination**

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

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

3. Election of Continuation Coverage

- a. You have 60 days to elect continuation of group coverage. The 60-day period begins on the date your group coverage would otherwise terminate due to a qualifying event or the date on which written notice of your right of continued group coverage is mailed, whichever is later.
- b. If you wish to continue group coverage as shown above, you must apply in writing to your Employer (not the Plan Manager). You must also pay your first monthly payment within 45 days of the date you elected to continue group coverage. If your coverage was terminated because of the death of the Covered Employee, your initial payment is not due until 90 days after you receive notice of the continuation right. Thereafter, your monthly payments are due and payable at the beginning of each month for which coverage is to be continued.
- c. You or your Covered Dependents must notify the Plan Sponsor within 60 days, when divorce, legal separation, a change in status resulting in a loss of eligibility as a dependent would end coverage or a second qualifying event occurs. The 60-day period begins on the date of the divorce, legal separation, change in dependent status or second qualifying event.

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

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

Independent School District #318 (Grand Rapids Public Schools)
820 NW First Avenue
Grand Rapids, MN 55744-2701

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

B. DISABLED EMPLOYEE

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

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

C. **REPLACEMENT OF COVERAGE AND CONFINED COVERED PERSONS**

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

D. **PUBLIC EMPLOYEES**

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

VIII. **CLAIMS PROCEDURES**

A. **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.

B. **PROCEDURES FOR REIMBURSEMENT OF SERVICES**

1. **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 180 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, Inc.
P.O. Box 1289
Minneapolis, MN 55440-1289

2. **Time of Payment of Claims.** Benefits will be paid under the Plan within a reasonable time period.
3. **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.
4. **Physical Examinations and Autopsy.** In the event the Plan Manager or Plan Sponsor requires information from a physical exam or autopsy to properly resolve a claim dispute, the Plan Manager or Plan Sponsor may request this information from you or your legal representative. Failure to submit the required information may result in denial of your claim.

5. **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.

C. TIME OF NOTIFICATION TO CLAIMANT OF CLAIMS

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

1. Pre-Service Claims (pre-certification requests).

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

When CareCheck receives a request for an urgent service, an initial determination must be made within 72 hours provided all information needed to make such a decision has been supplied. In the event the claimant has not furnished all of the data necessary to make a determination, the claimant will be notified within 24 hours. The claimant will be allowed 48 hours to respond to this request for additional information. Upon the receipt of the complete information, the claimant will be notified of the benefit determination within 48 hours or the end of time granted to the claimant to provide such information.

2. Post-Service Claims.

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

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

D. CLAIM DENIALS AND CLAIM APPEALS PROCESS FOR PRE-SERVICE CLAIMS

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

1. **First Level Appeal to the Plan Manager.** 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, Inc.
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

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

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

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

The time periods may be extended if you agree.

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

All notifications described above will comply with applicable law.

2. **Second Level of Appeal to the Plan Sponsor.** 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 Sponsor and submit issues, comments and additional information as appropriate to:

Attn: Fringe Benefit Committee
Independent School District #318 (Grand Rapids Public Schools)
820 NW First Avenue
Grand Rapids, MN 55744-2701

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

The time periods may be extended if you agree.

All notifications described above will comply with applicable law.

3. **External Review Procedures.** For external review procedures, please contact the Plan Sponsor.

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

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

1. **First Level Appeal to the Plan Manager.** 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, Inc.
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.

2. **Second Level of Appeal to the Plan Sponsor.** 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 Sponsor and submit issues, comments and additional information as appropriate to:

Attn: Fringe Benefit Committee
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The Plan Sponsor 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.

3. **External Review Procedures.** For external review procedures, please contact the Plan Sponsor.