Summary Plan Description

Bellin Health Systems, Inc. Medical Benefit Plan
Empower HRA NationalONE℠ Plan

SPD-900.2-WISN1EMP-34601-18

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The Empower HRA NationalONE^{SM} Plan combines an Employer funded Health Reimbursement Account (HRA) with a Medical Benefit Plan.

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

Empower HRA National*ONE*^{SM} Plan
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.

Coverage may also vary depending on whether you are receiving services from a network primary care provider, or from a network specialty care provider.

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.

These definitions apply to the Schedule of Payments. They also apply to the SPD.

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

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

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

For services provided by an out-of-network provider:
Any copayment or coinsurance is applied to the lesser of the providers' charge or the usual and customary charge for a service.

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

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

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

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

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

	Bellin Health Network Providers ACO	**Network Providers All Other Network Providers**	**Out-of-Network Providers**
Individual Calendar Year Deductible	$2,000	$2,000	$4,000
Family Calendar Year Deductible	$4,000	$4,000	$8,000
	The deductibles under Network benefits are combined.		
	The deductibles under the Network Benefits and the Out-of-Network Benefits are separate.		
Individual Calendar Year Out-of-Pocket Limit for Prescription Drugs	$2,600	$2,600	None.
Family Calendar Year Out-of-Pocket Limit for Prescription Drugs	$5,200	$5,200	None.
	The Out-of-Pocket Limit for prescription drugs under network benefits are combined.		
	The Out-of-Pocket Limit for prescription drugs does not include prescription drugs administered during treatment in a hospital, drugs for the treatment of growth deficiency, special dietary treatment for Phenylketonuria (PKU), injections administered in a doctor's office, diabetic supplies and amino acid based elemental formula. Durable medical equipment purchased at a pharmacy will not apply to the Out-of-Pocket Limit for prescription drugs. These listed services will apply toward the out of pocket limits for all other services, shown below.		
Individual Calendar Year Out-of-Pocket Limit	$4,000	$4,000	$8,000
Family Calendar Year Out-of-Pocket Limit	$8,000	$8,000	$16,000
	The out-of-pocket limits under Network Benefits are combined.		
	The out-of-pocket limits under the Network Benefits and the Out-of-Network Benefits are separate.		
	Out-of-Network Benefits above the usual and customary charge (see definition of charge above) do not apply to the out-of-pocket limit.		
	Any reduction in benefits for failure to comply with CareCheck® requirements will not apply toward the out-of-pocket limit.		

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

	***Network Providers Bellin Health ACO**	***Network Providers All Other Network Providers**	***Out-of-Network Providers**

***Coverage shown below is after deductible is satisfied, unless otherwise noted.**

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

A. AMBULANCE AND MEDICAL TRANSPORTATION

Ambulance and medical transportation (other than non-emergency fixed wing air ambulance transportation)	85% of the charges incurred.	See Network Providers Bellin Health ACO Benefits.	See Network Providers Bellin Health ACO Benefits.
Non-emergency fixed wing air ambulance transportation	85% of the charges incurred.	85% of the charges incurred.	50% of the charges incurred.

B. AUTISM TREATMENT

Intensive-level services *for children diagnosed with autism spectrum disorders. Intensive-level services must begin on or after two years of age and end before nine years of age.*	75% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
	Network Benefits and Out-of-Network Benefits, combined, are limited to 340 visits per calendar year.		
Intensive-Level Services Lifetime Maximum	Four years under this Plan or any other plan.	Four years under this Plan or any other plan.	Four years under this Plan or any other plan.
	The Lifetime Maximum is combined for the Network Benefits and the Out-of-Network Benefits.		
Nonintensive-level services *for Covered Persons diagnosed with autism spectrum disorders.*	75% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
	Network Benefits and Out-of-Network Benefits, combined, are limited to 170 visits per calendar year.		

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

		***Network Providers Bellin Health ACO**	***Network Providers All Other Network Providers**	***Out-of-Network Providers**
		***Coverage shown below is after deductible is satisfied, unless otherwise noted.**		
C.	**BEHAVIORAL HEALTH SERVICES**			
	Mental Health Services			
a.	Outpatient Services, including group therapy	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
b.	Inpatient Services	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
c.	Transitional Treatment Services	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
	Chemical Health Services			
a.	Outpatient Services, including group therapy	85% of the charges incurred. *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.*	60% of the charges incurred.	50% of the charges incurred.
b.	Inpatient Services	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
c.	Transitional Treatment Services	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
D.	**CHIROPRACTIC SERVICES**	75% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
E.	**CLINICAL TRIALS**	Coverage level is same as corresponding Bellin Health ACO Providers Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding All Other Network Providers Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Out-of-Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

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

	***Network Providers Bellin Health ACO**	***Network Providers All Other Network Providers**	***Out-of-Network Providers**
	***Coverage shown below is after deductible is satisfied, unless otherwise noted.**		
F. DENTAL SERVICES			
Accidental Dental Services	75% of the charges incurred. *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 6 months of the date of injury to be covered.*	60% of the charges incurred.	50% of the charges incurred.
Medical Referral Dental Services			
a. Medically Necessary Outpatient Dental Services	75% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
b. Medically Necessary Hospitalization and Anesthesia for Dental Care	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
c. Medical Complications of Dental Care	75% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
Oral Surgery	75% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
Treatment of Cleft Lip and Cleft Palate of a Dependent Child	75% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD)	75% of the charges incurred. *TMD/CMD services are limited to $1,250 per calendar year for Network Benefits and Out-of-Network Benefits combined.*	60% of the charges incurred.	50% of the charges incurred.

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

	***Network Providers Bellin Health ACO**	***Network Providers All Other Network Providers**	***Out-of-Network Providers**
	***Coverage shown below is after deductible is satisfied, unless otherwise noted.**		
G. DIAGNOSTIC IMAGING 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 (MRI/CT procedures are not considered preventive)	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.
For illness or injury			
a. Outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT)	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
b. Gastric Scopies	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.
c. All other outpatient diagnostic imaging services	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
H. DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
Special dietary treatment for Phenylketonuria (PKU)	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.

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

	***Network Providers Bellin Health ACO**	***Network Providers All Other Network Providers**	***Out-of-Network Providers**
	***Coverage shown below is after deductible is satisfied, unless otherwise noted.**		
Oral amino acid based elemental formula if it meets HealthPartners medical coverage criteria	85% of the charges incurred. *No more than a 90-day supply of diabetic supplies will be covered and dispensed at a time. Diabetic supplies purchased at a Tier 1 network pharmacy are not subject to the deductible.*	60% of the charges incurred.	50% of the charges incurred.
I. EMERGENCY AND URGENTLY NEEDED CARE SERVICES			
Urgently Needed care at clinics	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
Emergency care in a hospital emergency room, including professional services of a physician	85% of the charges incurred.	See Network Providers Bellin Health ACO Benefits.	See Network Providers Bellin Health ACO Benefits.
Inpatient emergency care in a hospital	85% 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.*	See Network Providers Bellin Health ACO Benefits.	See Network Providers Bellin Health ACO Benefits.
J. GENDER DYSPHORIA TREATMENT	Coverage level is same as corresponding Bellin Health ACO Providers Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding All Other Network Providers Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Out-of-Network Providers Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.
K. HEALTH EDUCATION	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.

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

	***Network Providers Bellin Health ACO**	***Network Providers All Other Network Providers**	***Out-of-Network Providers**
	***Coverage shown below is after deductible is satisfied, unless otherwise noted.**		
L. HEARING AID BENEFIT	85% of the charges incurred to a maximum benefit of one hearing aid per ear every five years.	60% of the charges incurred to a maximum benefit of one hearing aid per ear every five years.	50% of the charges incurred to a maximum benefit of one hearing aid per ear every five years.
	The hearing aid limits are combined under Network Benefits and Out-of Network Benefits.		
M. HOME HEALTH SERVICES			
Physical therapy, occupational therapy, speech therapy, respiratory therapy, home health aide services and palliative care	75% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
TPN/IV therapy, skilled nursing services, non-routine prenatal/postnatal services, and phototherapy	75% of the charges incurred.	60% of the charges incurred.	50% 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.	*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.*	*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.*
	For all other services that meet the home health services requirements described in this SPD, there is a maximum of 120 visits per calendar year.	*For all other services that meet the home health services requirements described in this SPD, there is a maximum of 120 visits per calendar year.*	*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.		

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

		***Network Providers Bellin Health ACO**	***Network Providers All Other Network Providers**	***Out-of-Network Providers**
		***Coverage shown below is after deductible is satisfied, unless otherwise noted.**		
	Routine postnatal well child visits	75% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
		The routine postnatal well child visits do not count toward the visit limit above.		
N.	**HOME HOSPICE SERVICES**	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
		Respite care is limited to five days per episode, and respite care and continuous care combined are limited to 30 days.		
O.	**HOSPITAL AND SKILLED NURSING FACILITY SERVICES**			
	Medical or Surgical Hospital Services			
	a. Inpatient Hospital Services	85% of the charges incurred.	60% of the charges incurred.	50% 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)*	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
	Skilled Nursing Facility Care	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
		Limited to 120 day maximum per period of confinement.	*Limited to 120 day maximum per period of confinement.*	*Limited to 120 day maximum per period of confinement.*
		Each day of services provided under the Network Benefits and Out-of-Network Benefits, combined, count toward the maximums shown above.		

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

	***Network Providers Bellin Health ACO**	***Network Providers All Other Network Providers**	***Out-of-Network Providers**
	***Coverage shown below is after deductible is satisfied, unless otherwise noted.**		
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. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.
For illness or injury	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
Q. MASTECTOMY RECONSTRUCTION BENEFIT	Coverage level is same as corresponding Bellin Health ACO Providers Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding All Other Network Providers Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Out-of-Network Providers Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.
R. MEDICATION THERAPY DISEASE MANAGEMENT PROGRAM	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	No coverage.
S. OFFICE VISITS FOR ILLNESS OR INJURY			
Primary Care Providers	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
Specialty Care Providers	75% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.

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

	***Network Providers Bellin Health ACO**	***Network Providers All Other Network Providers**	***Out-of-Network Providers**
	***Coverage shown below is after deductible is satisfied, unless otherwise noted.**		
Convenience clinics	100% of the charges incurred at Bellin Health FastCare. 85% of the charges incurred at all other convenience clinics.	60% of the charges incurred.	50% of the charges incurred.
Scheduled telephone visits	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
Virtual visits	100% of the charges incurred at Bellin Health. 85% of the charges incurred at all other clinics.	60% of the charges incurred.	No coverage.
Injections administered in a physician's office			
Allergy injections	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
All other injections	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
T. 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	75% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred. *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 Providers Bellin Health ACO**	***Network Providers All Other Network Providers**	***Out-of-Network Providers**
	***Coverage shown below is after deductible is satisfied, unless otherwise noted.**		
Habilitative therapy	75% of the charges incurred. *Habilitative physical therapy Network Benefits and Out-of-Network Benefits, combined, are limited to 20 visits per calendar year.* *Habilitative occupational therapy Network Benefits and Out-of-Network Benefits, combined, are limited to 20 visits per calendar year.* *Habilitative speech therapy Network Benefits and Out-of-Network Benefits, combined, are limited to 20 visits per calendar year.*	60% of the charges incurred.	50% of the charges incurred.
U. PRESCRIPTION DRUG SERVICES	**Drugs and medications must be part of the formulary and obtained at a Bellin Health or Shopko pharmacy**	**Drugs and medications must be part of the formulary and obtained at All Other Network pharmacies**	
Outpatient Drugs (except as specified below)			
Generic formulary drugs	$10 copayment and 100% thereafter per prescription for up to a 31-day supply. $20 copayment and 100% thereafter per prescription for a 32-62-day supply. $30 copayment and 100% thereafter per prescription for a 63-90-day supply. Deductible does not apply.	$15 copayment and 100% thereafter per prescription for up to a 31-day supply. Deductible does not apply.	50% of the charges incurred.

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

	***Network Providers Bellin Health ACO**	***Network Providers All Other Network Providers**	***Out-of-Network Providers**
	***Coverage shown below is after deductible is satisfied, unless otherwise noted.**		
Brand formulary drugs	65% of the charges incurred, subject to a minimum copayment of $30 and a maximum copayment of $135 for up to a 31-day supply. 65% of the charges incurred, subject to a minimum copayment of $60 and a maximum copayment of $270 for a 32-62-day supply. 65% of the charges incurred, subject to a minimum copayment of $90 and a maximum copayment of $405 for a 63-90-day supply. Deductible does not apply. *Formulary contraceptives are covered at 100% of the charges incurred. 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. Deductible does not apply.* *Drugs for the treatment of sexual dysfunction are not covered.*	60% of the charges incurred, subject to a minimum copayment of $40 and a maximum copayment of $150 for up to a 31-day supply. Deductible does not apply. *Formulary contraceptives are covered at 100% of the charges incurred. 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. Deductible does not apply.* *Drugs for the treatment of sexual dysfunction are not covered.*	50% of the charges incurred. *Drugs for the treatment of sexual dysfunction are not covered.*
Tobacco cessation products, as determined by HealthPartners. Must be prescribed by a licensed provider.	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.

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

	***Network Providers Bellin Health ACO**	***Network Providers All Other Network Providers**	***Out-of-Network Providers**
	***Coverage shown below is after deductible is satisfied, unless otherwise noted.**		
Mail Order Drugs	Mail order drugs are only available through HealthPartners mail order service. See All Other Network Providers Benefit.	You may also get outpatient prescription drugs which can be self-administered through HealthPartners mail order service or other retail pharmacies. Outpatient drugs ordered through this service are covered at the benefit percent and copayment shown below.	Mail order drugs are only available through HealthPartners mail order service. See All Other Network Providers Benefit.
Generic formulary drugs		$25 copayment and 100% thereafter per prescription for up to a 90-day supply. Deductible does not apply.	
Brand formulary drugs		65% of the charges incurred, subject to a minimum copayment of $75 and a maximum copayment of $405 for up to a 90-day supply. Deductible does not apply. Specialty drugs are not available through the mail order service.	
Diabetic Supplies purchased at a pharmacy			
Generic formulary drugs	$10 copayment and 100% thereafter per prescription for up to a 31-day supply. $20 copayment and 100% thereafter per prescription for a 32-62-day supply. $30 copayment and 100% thereafter per prescription for a 63-90-day supply. Deductible does not apply.	$15 copayment and 100% thereafter per prescription for up to a 31-day supply. Deductible does not apply.	50% of the charges incurred.

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

	***Network Providers Bellin Health ACO**	***Network Providers All Other Network Providers**	***Out-of-Network Providers**
	***Coverage shown below is after deductible is satisfied, unless otherwise noted.**		
Brand formulary drugs	65% of the charges incurred, subject to a minimum copayment of $30 and a maximum copayment of $135 for up to a 31-day supply. 65% of the charges incurred, subject to a minimum copayment of $60 and a maximum copayment of $270 for a 32-62-day supply. 65% of the charges incurred, subject to a minimum copayment of $90 and a maximum copayment of $405 for a 63-90-day supply. Deductible does not apply.	60% of the charges incurred, subject to a minimum copayment of $40 and a maximum copayment of $150 for up to a 31-day supply. Deductible does not apply.	50% of the charges incurred.
Specialty drugs which are self-administered	No coverage.	100% of the charges incurred, subject to a copayment of $200 per prescription. Deductible does not apply.	No coverage.
Drugs for the treatment of growth deficiency	No coverage.	85% of the charges incurred. *Specialty drugs are limited to drugs on the specialty drug list, and must be obtained from a designated vendor.*	50% of the charges incurred.

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

***Network Providers Bellin Health ACO**	***Network Providers All Other Network Providers**	***Out-of-Network Providers**

***Coverage shown below is after deductible is satisfied, unless otherwise noted.**

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 31-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. A 90-day supply will be covered and dispensed at a time only at pharmacies that participate in the HealthPartners extended day supply program. No more than a 31-day supply of specialty drugs will be covered and dispensed at a time, unless it's a manufacturer supplied drug that cannot be split that supplies the Covered Person with more than a 31-day supply.

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

If you request a brand drug when there is a generic equivalent, the brand drug will be covered up to the charge that would apply to the generic drug, minus any required copayment.

If a physician requests that a brand name drug be dispensed as written (DAW), and it is determined that the brand name drug is medically necessary, the drug will be paid at the brand name drug benefit.

Prescription drugs are subject to the calendar year out of pocket limit for prescription drugs shown at the beginning of the Schedule of Payments.

Prescription drug copayments are not eligible for reimbursement from the HRA.

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

	***Network Providers Bellin Health ACO**	***Network Providers All Other Network Providers**	***Out-of-Network Providers**
	***Coverage shown below is after deductible is satisfied, unless otherwise noted.**		
V. PREVENTIVE SERVICES			
1. Routine health exams and periodic health assessments	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.
2. Child health supervision services	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.
3. Routine prenatal care	The first office visit, pregnancy test and ultrasound are paid at 100%, not subject to the deductible. Then all charges will be covered at 75% of the charges incurred.	The first office visit, pregnancy test and ultrasound are paid at 100%, not subject to the deductible. Then all charges will be covered at 60% of the charges incurred.	50% of the charges incurred.
4. Routine postnatal care	75% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
5. Routine screening procedures for cancer	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.
6. Routine eye exams	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	No coverage.
7. Routine hearing exams	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.
7. Professional voluntary family planning services	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.
8. Adult immunizations	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.
9. Gastric Scopies	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.

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

	***Network Providers Bellin Health ACO**	***Network Providers All Other Network Providers**	***Out-of-Network Providers**
	***Coverage shown below is after deductible is satisfied, unless otherwise noted.**		
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. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.
10. Obesity screening and management	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.
W. Specific Disease Conditions Benefit for Employees and Covered Spouses (Arthrosclerosis/ Cardiovascular, Disease, Diabetes, Hyperlipidemia and Hypercholesterolemia, Hypertension, Obesity and Tobacco Use) *This benefit covers primary care visits and certain laboratory services.*	100% of the charges incurred when provided by a Bellin Medical Group primary care provider. Deductible does not apply. 85% of the charges incurred when provided by any other Bellin Health ACO Primary Care Network provider.	60% of the charges incurred.	50% of the charges incurred.
X. TRANSPLANT SERVICES	85% of the charges incurred.	60% of the charges incurred.	50% of the charges incurred.
Y. TRANSPLANT TRAVEL BENEFIT	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.
	Expenses for travel and lodging for the Covered Person (the transplant recipient) and one adult companion, or up to two companions for a transplant recipient that is a minor dependent, may be covered up to a maximum benefit of $10,000 per lifetime. Lodging coverage is limited to $50 per day for the patient or up to $100 per day for the patient plus one companion.		

Health Reimbursement Account (HRA)

Your employer has established a HRA (a notional bookkeeping account) for you. Your Employer funds a specified amount to your HRA to be used for eligible expenses (as outlined in this SPD).

The HRA along with your medical Plan, as described in this SPD, are a single employer plan and for purposes of this SPD are collectively referred to as the "Plan".

Qualifying for the HRA	You and your spouse (if enrolled) must complete steps 1 and 2 of the Wellness Rewards: 1) Health Risk Assessment within 30 days of your date of hire or date that you experience a qualifying event for enrollment and annually within specified deadline. 2) Wellness Statement showing you and/or spouse are up-to-date with preventive screenings within 90 days of your date of hire or date you experience a qualifying event for enrollment and annually within specified deadline. See Health Plan Wellness Rewards at the end of this SPD for more information.
Employer Funding	
Single	$550
Single + One Dependent	$1,100
Family	$1,100
Funding For Mid-Year Hires	If coverage is effective after the beginning of the calendar year, employer funding will be prorated on a monthly basis. Regardless of effective date of coverage, employer funding will be made in full for the applicable month.
HRA Rollover	Any unused funds remaining in your account after March 31, 2019 will roll over each year for future medical expenses. The rollover amount will not be determined until after March 31, 2019. These funds will not be available for use until after the rollover has occurred.

SPECIFIC INFORMATION ABOUT THE PLAN

Employer:	Bellin Memorial Hospital dba Bellin Health Systems, Inc.
Name of the Plan:	The Plan shall be known as the Bellin Memorial Hospital dba Bellin Health Systems, Inc. Medical Benefit Plan which provides employee and dependent medical benefits
Address of the Plan:	744 South Webster Avenue Green Bay, WI 54305 920-445-7240
Group Number:	34601
IRS Employer Identification Number:	39-0884478
Plan Identification Number:	512
Plan Year:	The period beginning on each January 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.)	Bellin Memorial Hospital dba Bellin Health Systems, Inc.
Agent for Service of Legal Process:	General Counsel for Bellin Memorial Hospital dba Bellin Health Systems, Inc.
Named Fiduciary: (has the authority to control and manage the operation and administration of the Plan; has discretionary authority to determine eligibility for benefits or to construe the terms of the Plan.)	For purposes of determining eligibility and enrollment, and for funding claims paid and all related activities and responsibilities under the Plan, Bellin Memorial Hospital dba Bellin Health Systems, Inc. is the named fiduciary. Solely for purposes of determining coverage of claims, HealthPartners Administrators, Inc. is the named fiduciary.
Funding:	Claims under the Plan are paid from the general funds of the Employer.
Plan Manager: (provides administrative services to the Plan Sponsor in connection with the operation of the Plan, such as processing of claims and other functions, as may be delegated to it.)	HealthPartners Administrators, Inc. 8170 33rd Avenue South P.O. Box 1309 Minneapolis, MN 55440-1309 952-883-6000
Network Providers:	Open Access Network
Contributions:	Please refer to the most recent enrollment material for information regarding contributions to your Plan which is hereby incorporated by this reference.

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.

Employer ("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) establish and revise the method of accounting for the Plan; (2) establish rules and prescribe any forms required for administration of the Plan; (3) change the Plan; and (4) 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 federal laws governing welfare health benefits, the requirements of the Internal Revenue Code or ERISA, or for any other reason. The Plan may be changed to transfer the Plan's liabilities to another plan or split the Plan into two or more parts.

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

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

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

RIGHTS UNDER ERISA

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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

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

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

CONTINUE GROUP HEALTH PLAN COVERAGE

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

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

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

ASSISTANCE WITH YOUR QUESTIONS

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

RESPONSIBILITIES OF COVERED PERSONS

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 "*my*HealthPartners" account at www.healthpartners.com/bellin 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 assign or in any way transfer your rights 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 "*my*HealthPartners" account at www.healthpartners.com/bellin for a current list.

Network Providers. This is any one of the participating licensed physicians, dentists, mental and chemical health or other health care providers, facilities and pharmacies, which 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 "*my*HealthPartners" account at www.healthpartners.com/bellin or create one at www.healthpartners.com/bellin. 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 your current primary care physician provider is no longer a part of the network, you may continue to receive services from the provider, for the period of time shown below, and such services may be considered a covered Network Benefit.

1. Until the end of the current calendar year if the material/information provided to you included a primary care physician provider who is not a part of the network; or
2. If you are undergoing a course of treatment with a provider who is not a primary care physician, services will be continued until the shorter of (a) 90 days after the provider's participation under the network ends, or (b) until the end of the course of treatment, or (c) until the end of the calendar year; or
3. If your course of treatment is maternity care, and you are beyond the first trimester of your pregnancy when the provider's participation under the network ends, services may be continued until the end of post natal care for you and the newborn child.

Continuity of care benefits will not be available or may be discontinued if the provider no longer practices in the service area, or is terminated from network for misconduct.

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 "*my*HealthPartners" account at www.healthpartners.com/bellin 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. Occasionally, HealthPartners may, in its sole discretion, apply a previous carrier's approach to coverage for a limited period of time to accommodate a member's specific needs for continuity of care when an employer is moving from another carrier to HealthPartners coverage.

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; and (2) 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 "*my*HealthPartners" account at www.healthpartners.com/bellin for a list.

Durable medical equipment and supplies must be obtained from 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.

Multidisciplinary pain management must be provided at designated facilities.

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

Call Member Services for more information on authorization requirements or 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. CARECHECK®

It is your responsibility to notify CareCheck® of all services requiring review, as shown in 1. below. Failure to follow CareCheck® procedures may result in a reduction of the maximum coverage available to you under the Plan. You can designate another person to contact CareCheck® for you.

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 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 8**00-316-9807** (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, COST OF COVERAGE, EFFECTIVE DATE, LATE ENROLLMENT, SPECIAL ENROLLMENT PERIOD, SPECIAL RULES RELATING TO MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM ("CHIP"), CHANGES IN BENEFITS AND TERMINATION

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

a. All employees in a benefit eligible classification (Full-time or Regular Part-time status).

Employees must enroll themselves and any eligible dependents within 31 days of the date they first become eligible. The employee must enroll a newly acquired dependent (such as a new spouse) within 31 days of when the new dependent is first acquired. There may be additional situations when the employee is eligible to enroll after the first 31 days of eligibility. If there are any questions, contact the Plan Sponsor and see "**LATE ENROLLMENT**" below.

b. Employees who meet eligibility requirements during the 12 month measurement period as required by the Affordable Care Act (ACA) regulations will have been deemed to have met the eligibility requirements for the resulting stability period as required by (ACA) regulations.

c. All early retirees and retirees as defined by the Plan Sponsor.

d. Qualified Retiree: For employees who retired before January 1, 2009, a qualified retiree is an employee who, at the time of retirement from active service with Bellin, was between the ages of 55 and 65; had five or more years of service with at least 1,000 work hours per year; and who was in a pension pay status under the Bellin Employee's Pension Plan or met the same requirements under the Bellin's Health 401(k) Retirement Plan.

For employees who retire on or after January 1, 2009, a qualified retiree is an employee who, at the time of retirement from active service with Bellin, was between the ages of 60 to 65; and had fifteen or more years of service with at least 1,000 hours per year.

A qualified retiree who was enrolled on the Plan as of the date of retirement is eligible to continue medical coverage on the plan until the qualified retiree reaches the age of 65, at which time retiree coverage shall end. A qualified retiree may also cover a spouse and dependents during the period of retiree coverage on the same terms and conditions as an active employee. A qualified retiree will be required to pay a premium in an amount and manner as specified by the Bellin in order to maintain retiree coverage. Failure to pay any required premium in a timely manner shall result in the termination of retiree coverage for the qualified retiree and any spouse or dependents retroactive to the date last premium payment was received.

2. COST OF COVERAGE. You and Bellin Health Systems, Inc. share in the cost of the Plan. Your contribution (or premium) amount depends on whether you and your spouse (if covered):

a. participate in the voluntary Health Risk Assessment (HRA) within 30 days of date of hire or date of eligibility,

b. submit a completed Wellness Statement within 90 days of your date of hire or date of eligibility, and

c. the number of family members you choose to enroll.

There are four premium levels, based on employee and spouse (if applicable) scores and if the Wellness Statement was completed:

HRA SCORE	LEVEL	PREMIUM
86-100 and Wellness Statement completed	**Gold**	Lowest (Best)
71-85 and Wellness Statement completed	**Silver**	Lower (Better)
70 or below and Wellness Statement completed	**Bronze**	Higher Rate
No HRA taken and/or No Wellness Statement completed	**Base**	Highest

Note: Both employee and spouse must qualify for the same premium level, or the lowest HRA score or highest premium cost qualified for by either employee or spouse will determine premium level for employee.

Examples:

If employee and spouse both take the HRA and complete Wellness Statements and employee scores 86 on the HRA, and spouse scores 70 on the HRA; the employee will qualify for the Bronze level premium.

If employee takes the HRA receiving a score of 85 and completes the Wellness Statement and Spouse takes the HRA receiving a score of 92, but does not complete the Wellness Statement; employee will qualify for the Base level premium.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Your contributions are subject to review and Bellin Health Systems, Inc. reserves the right to change your contribution amount from time to time.

3. EFFECTIVE DATE. Provided the employee is actively at work on that date, the employee's and any dependent's effective date is the first of the month following the date of hire or the date the employee moves to an eligible status.

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.

4. LATE ENROLLMENT. If you are a late enrollee, you may only enroll yourself and any eligible dependents during the Employer's annual open enrollment or if you or your dependents have met the criteria under "**SPECIAL ENROLLMENT PERIOD**" below.

5. 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, the date of marriage;
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.

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. **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.

8. **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 same day in which the employee's eligibility ceases, unless group continuation is elected as described in section VII.

   c. When a Covered Dependent no longer meets this Plan's definition of eligible dependent, coverage for that dependent terminates on the last day of the month in which the dependent's eligibility ceases, unless group continuation is elected as described in section VII.

   d. When the maximum period under the group continuation coverage described in section VII. 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. LEAVE OF ABSENCE COVERAGE

Eligibility for Leave of Absence: Eligibility for a Leave of Absence refers to any Employee not actively at work due to an injury and/or illness will be handled as follows:

Approved Medical Leave of Absence: The employee is treated as an active employee for 90 days following the expiration of any approved state or federal leave absence under the FMLA/applicable State FMLA regulations.

Approved Non-Medical Leave of Absence: The employee is to be treated as an active employee for 90 days following any approved NON-FMLA/ applicable State FMLA leave at which time when the 90 days expires they will be offered Cobra Continuation based on applicable Cobra Rules.

I. 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 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.

Certain limited information of all family members enrolled in the plan will be viewable on the HRA website by the enrolled employee. By enrolling in this Plan you are acknowledging that you and all dependents enrolled in the Plan, understand that you, as the enrolled employee, will have access to limited information about all the claims submitted to your HRA for reimbursement.

II. DEFINITIONS OF TERMS USED

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

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.

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

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

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

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

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

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

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

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

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 as provided in section VII. of this SPD.

1. **Spouse**. This is a Covered Employee's current legal spouse. If more than one spouse is covered as an employee under the Plan, only one spouse shall be considered to have any eligible dependents.

2. **Child.** This is a Covered Employee's (a) natural or legally adopted child (effective from the date of adoption or the date placed for adoption, whichever is earlier); (b) child for whom the Covered Employee or the Covered Employee's spouse is the legal guardian; (c) step-child of the Covered Employee (that is, the child of the Covered Employee's spouse); or (d) a child covered under a valid qualified medical child support order (as the term is defined under Section 609 of the Employee Retirement Income Security Act (ERISA) and its implementing regulations) which is enforceable against a Covered Employee.* In each case the child must be either under 26 years of age or a disabled dependent, as described below. Coverage will terminate the end of the month in which the child turns age 26.

3. **Disabled Dependent.** This is a Covered Employee's dependent as referred to in 2. 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. 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.

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

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

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

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

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. The formulary, and information on drugs that require prior authorization, are available by logging onto your "*my*HealthPartners" account at www.healthpartners.com/bellin or by calling Member Services.

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

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

* 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.

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

Health Reimbursement Account (HRA). Your employer has established a HRA (a notional bookkeeping account) for you. Your employer funds a specified amount to your HRA to be used for eligible expenses (as outlined in this SPD).

The HRA along with your medical Plan, as described in this SPD, are a single employer plan and for purposes of this SPD are collectively referred to as 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:
1. the first period in which the individual is eligible to enroll under the Plan; or
2. the Employer's annual open enrollment period; or
3. a special enrollment period.

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

Medically Necessary/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 appropriately licensed mental health therapist, lawfully performing a mental or chemical health service in accordance with governmental licensing privileges and limitations, who renders mental or chemical health services to Covered Persons as covered under the Plan. For inpatient services, these mental health professionals must be working under the order of a physician.

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

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

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.

Prescription drugs include drugs for the treatment of HIV infection if the drug is approved by the FDA for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection, including investigational drugs which are prescribed and administered in accordance with the treatment protocol approved for the investigative new drug.

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®.

Primary Care Providers: These are providers in the following categories: Family Practice, General Practice, Internal Medicine, Pediatrics, Adolescent Medicine, Adult Medicine and Geriatrics.

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 normal body function.

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

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 Care Providers: These are providers who are not in the following categories: Family Practice, General Practice, Internal Medicine, Pediatrics, Adolescent Medicine, Adult Medicine and Geriatrics.

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 "*my*HealthPartners" account at www.healthpartners.com/bellin or by calling Member Services.

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.

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

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 "*my*HealthPartners" account at www.healthpartners.com/bellin or by calling Member Services.

Eligible expenses are expenses incurred by you or your Covered Dependents that satisfy all of the conditions described in this SPD up to the annual specified dollar amount available to you in your HRA, with the exception of prescription drug expenses which are not eligible for reimbursement out of your HRA.

The funds in your HRA are used to pay for Eligible Expenses. After you have used your HRA funds, you must pay any member liability due under the Plan.

A. 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 "*my*HealthPartners" account at www.healthpartners.com/bellin or by calling Member Services.

B. AUTISM TREATMENT

Please call Member Services at 952-883-7000 or 866-443-9352 (toll-free) before receiving any autism treatment services from an out-of-network provider.

Your network provider will coordinate the authorization process for any autism treatment services. You may call Member Services at 952-883-7000 or 866-443-9352 (toll-free)if you have any questions or concerns regarding prior authorization of your treatment.

The Plan covers prior authorized evidence-based intensive-level and nonintensive-level treatment of autism spectrum disorders (autism disorder, Asperger's syndrome or pervasive development disorder not otherwise specified).

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/bellin or by calling Member Services.

C. BEHAVIORAL HEALTH SERVICES

Transitional Treatment Services. These are services for the treatment of nervous or mental disorders, alcoholism or other drug abuse problems which are provided to a Covered Person in a less restrictive manner than are inpatient hospital services but in a more intensive manner than are outpatient services. Transitional treatment services are services offered by a provider, and certified by the local Department of Health Services for each of the following services (except item f.):

(a) Mental health services for covered adults in a day treatment program.
(b) Mental health services for covered children in a day hospital treatment program.
(c) Services for person with chronic mental illness provided through a community support program.
(d) Residential treatment programs for alcohol and/or drug dependent Covered Persons.
(e) Alcohol and other drug abuse services in a day treatment program.
(f) Intensive outpatient programs for the treatment of psychoactive substance use disorders provided in accordance with the patient placement criteria of the American Society of Addictive Medicine.
(g) Services for persons who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided.

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 provides coverage for mental health treatment ordered by a Wisconsin 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 services must be a covered benefit under this Plan, and the service must be provided by a network provider as required by law.

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) Partial hospitalization services in a licensed hospital or community mental health center;
(5) Psychotherapy and nursing services provided in the home if authorized by HealthPartners; and
(6) Treatment for gender dysphoria that meets medical coverage criteria.

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

c. **Transitional Treatment Services.** The Plan covers transitional treatment services described above for the treatment of mental health disorders.

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 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.** The Plan covers medically necessary inpatient services in a hospital or a licensed residential primary treatment center.

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 Services.

c. **Transitional Treatment Services.** The Plan covers transitional treatment services for the treatment of alcohol or drug abuse.

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 "*my*HealthPartners" account at www.healthpartners.com/bellin or by calling Member Services.

D. CHIROPRACTIC SERVICES

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

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

E. 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.

F. 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 clinic. 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. Treatment of Cleft Lip and Cleft Palate: The Plan covers treatment of cleft lip and cleft palate of a dependent child, including orthodontic treatment and oral surgery directly related to the cleft. Dental services which are not required for the treatment of cleft lip or cleft palate are not covered. If a dependent child covered under this Plan is also covered under a dental plan which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services.

5. Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD). The Plan covers: a) diagnostic treatment, includes exam, radiographs, and applicable imaging studies and consultation; b) non-surgical treatment, includes exams, arthorocentesis and trigger-point injections; and c) surgical treatment, includes arthorocentesis, arthoplasty, arthotomy, open or closed reduction of dislocations and TMJ implants.

G. 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 Computing Tomography (CT) must be provided at a designated facility.

H. 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 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.

   The Plan covers special dietary treatment for Phenylketonuria (PKU) and oral amino acid based elemental formula if it meets HealthPartners medical coverage criteria.

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 oral appliances for cleft lip and cleft palate, payment will not exceed the cost of an alternate piece of equipment or service that is effective, medically necessary and enables Covered Persons to conduct standard activities of daily living.
   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, 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 "*my*HealthPartners" account at www.healthpartners.com/bellin 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. Adjustments to shoes to accommodate braces.
m. Orthotic devices.
n. Other equipment and supplies, including but not limited to assistive devices, that the Plan determines are not eligible for coverage.

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

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. The coverage policy for diabetic supplies includes information on the required models and brands. These medical policies (medical coverage criteria) are available by logging onto your "*my*HealthPartners" account at www.healthpartners.com/bellin or by calling Member Services.

I. EMERGENCY AND URGENTLY NEEDED CARE 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 hours.

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

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

The Plan **must be** notified within two working days of admission to 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.

J. GENDER DYSPHORIA TREATMENT

Prior authorization is required for any surgery related to Gender Dysphoria.

The Plan covers treatment of gender dysphoria limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described under BEHAVIORAL HEALTH SERVICES in this section.

- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for sample during an office visit) is provided as described under PRESCRIPTION DRUG SERVICES-OUT PATIENT in this section.
  - Cross-sex hormone therapy dispenses from a pharmacy is provided as described under PRESCRIPTION DRUG SERVICES, Outpatient Drugs.

- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.

- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.

- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

Male to Female:
- Clitoroplasty (creation of clitoris)
- Labiaplasty (creation of labia)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Urethroplasty (reconstruction of female urethra)
- Vaginoplasty (creation of vagina)

Female to Male:
- Bilateral mastectomy or breast reduction
- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophoroectomy (removal of fallopian tubes and ovaries)
- Scotoplasty (creation of scrotom)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all the following criteria:

  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person.

The assessment must document that the Covered Person meets all of the following criteria:

- Persistent, well-documented Gender Dysphoria.
- Capacity to make a fully informed decision and to consent for treatment.
- Must be 18 years or older.
- If significant medical or mental health concerns are present, they must be reasonably well controlled.
- Complete at least 12 months of successful continuous full-time real life experience in the desired gender.
- Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

- The treatment plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

K. HEALTH EDUCATION

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

L. HEARING AID BENEFIT

The Plan covers evaluation for the need for a hearing aid and medically necessary hearing aids when arranged through and authorized by a network physician. This benefit is limited to one hearing aid per ear for each Covered Person in each five calendar year period. A hearing aid appliance is limited to one of the following types: 1) in the ear; 2) behind-the-ear (air or bone conduction); 3) conventional (on the body); or 4) eye glass frame hearing appliance. The appliance must be prescribed by a network physician. If another type of hearing aid appliance is prescribed, the current average dollar cost for the above named appliances shall be the amount which is covered toward the cost of such other appliance.

M. 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.

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.

N. 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.

O. 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.

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

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.

P. LABORATORY SERVICES

The Plan covers laboratory tests when ordered by a provider and provided in a clinic or outpatient hospital facility. This includes blood tests to detect lead exposure in children between the ages of 6 months and 72 months.

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. MEDICATION THERAPY DISEASE MANAGEMENT PROGRAM

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

The Program covers consultations with a designated network pharmacist.

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

S. OFFICE VISITS FOR ILLNESS OR INJURY

The Plan covers the following when medically necessary: professional medical and surgical services and related supplies, 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.

T. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY

The Plan covers the following physical therapy, occupational therapy and speech therapy services:

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

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

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 18.
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.
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. 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 "*my*HealthPartners" account at www.healthpartners.com/bellin or by calling Member Services.

W. 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.

Kidney Disease Treatment. The Plan covers services for kidney disease treatment, including dialysis, transplantation and donor related services. Donor related expenses are covered as described above.

X. TRANSPLANT TRAVEL BENEFIT

The Plan may provide travel and lodging when a Covered Person needs a transplant and a designated transplant center is greater than 50 miles from the Covered Person’s primary address.

Covered services are based on established medical policies. These medical policies (medical coverage criteria) are available by logging onto your “*my*HealthPartners” account at www.healthpartners.com/bellin or by calling Member Services.

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

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 does not cover these services. The Plan considers the following transplants to be investigative and does not cover them: surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, non-human organ implants and/or transplants and other transplants not specifically listed in this SPD. While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered.
4. Rest and respite services and custodial care, except as specified under the Home Hospice 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 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. This exclusion does not apply to medically necessary complications related to an excluded service if they would otherwise be covered under this SPD.
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, and all weight loss/bariatric surgery.
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. However, if a court orders an examination for a child, the initial examination will be covered. Court ordered treatment for behavioral health services will be covered consistent with the Plan Manager's medical coverage criteria (available by logging onto your "*my*HealthPartners" account at www.healthpartners.com/bellin or by calling Member Services).
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; diagnosis and treatment of infertility, including drugs for the treatment of infertility; artificial insemination; and sperm, ova or embryo acquisition, retrieval or storage.
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, 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 onto your "*my*HealthPartners" account at www.healthpartners.com/bellin 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, except as specified in this SPD under the Transplant Travel Benefit.
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.
31. 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 restoration, or (5) received beyond 24 months from the date of injury.
32. 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.
33. Charges for elective home births.
34. 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
35. Treatment, procedures, or services or drugs which are provided when you are not covered under this Plan.
36. Care that is not rehabilitative in nature and medically necessary for the diagnosis and/or treatment of acute neuromusculoskeletal conditions.
37. Services provided by naturopathic providers.
38. 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.
39. 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.
40. Elective abortions, except in situations where the life of the mother would be endangered if the fetus is carried to full term.
41. Medical cannabis.
42. Acupuncture.
43. Drugs on the Excluded Drug List. The Excluded Drug List includes select drugs within a therapy class that are not eligible for coverage.
44. Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders that are not evidence based, including ABA, IEIBT, and Lovaas.
45. Drugs for the treatment of sexual dysfunction.
46. Hair prostheses (wigs).

47. Oral surgery to remove wisdom teeth.
48. Orthognathic treatment or procedures and all related services.
49. Occlusal appliances.
50. Procedures (such as panniculectomy, abdominoplasty, thighplasty, brachioplasty and mastopexy) are excluded even when there is a medical condition, such as rash or irritation.
51. Non-surgical treatment, even for morbid obesity; and surgical treatment of obesity even if there is a diagnosis of morbid obesity.
52. Eye exercise therapy.
53. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: 1) learning or reading disabilities; 2) attention deficit/hyperactively disorder; 3) TBI; or 4) dyslexia.
54. Expenses for health services and supplies that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed force of any country.
55. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
56. Health services provided in a foreign country, unless required as emergency health services.
57. Biofeedback.
58. Massage therapy.
59. Adjustments to shoes to accommodate braces.
60. Orthotic devices.

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, and they make final authorization for covered services. In certain circumstances where prior authorization is required for a covered service, Covered Persons may be directed by the Plan Manager to the most cost-effective site of care to receive covered services. If the site to which the Covered Person is being directed has a higher cost to the Covered Person than the original physician directed site of care, the benefit category with the lower cost to the Covered Person will apply.

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

Coverage determinations are based on 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: 952-883-7000 Outside the metro area: 866-443-9351 (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

If claims are automatically submitted to your HRA for payment consideration (see the HRA Claim Payment subsection in the Claims Procedures section of this SPD), you MUST opt out of automatic claims submission if either of the following is true:

1. **You have dual health plan coverage through a spouse.** In these instances reimbursement out of the HRA would not be appropriate if the claim may be paid by another source.

2. **You have a dependent covered under your health plan who does not qualify as a dependent under the Internal Revenue Code Section 152.** Reimbursement out of the HRA for dependents who meet the definition of dependent under the health plan, but not IRC Code section 152 are not allowable.

Automatic Claims Submission Forms are available on-line at www.healthpartners.com/bellin or by calling Member Services.

If you opt out of the automatic claim submission to your HRA, you must submit a manual claim for your eligible expenses in order to receive reimbursement from your HRA.

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.

For purposes of Coordination of Benefits, the HRA portion of this Plan is always secondary to medical coverage under another plan.

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.

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

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.
3. For Covered Persons under age 65, who are covered by Medicare because of disability (other than end stage renal disease), when (1) the Employer employs fewer than 100 employees and the Covered Person or their spouse or parent has group health plan coverage due to current employment, or (2) the Covered Person or their spouse or parent has coverage not due to current employment, regardless of the number of employees of the Employer.

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

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

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

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

VII. CONTINUATION OF GROUP COVERAGE

Although your coverage under this medical SPD along with your HRA is considered a single employer plan, you may elect to continue your coverage under either:

- Both medical benefits under the medical SPD and the HRA described in this SPD; or
- Only the medical benefits under the medical SPD.

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

1. Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You may Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced (including loss of coverage caused by leave of absence)	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member are eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible Dependent (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
Bellin Health Systems, Inc., files for bankruptcy under Title 11, United States Code[2]	Date of Death	36 months[3]	36 months[3]

[1]Subject to the following conditions: (i) notice of the disability must be provided as set forth below within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months of coverage over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 month coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]This is a qualifying event for any Retired Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date of bankruptcy was filed.

[3]From the date of the Participant's death if the Participant dies during the continuation coverage.

How your Medicare Eligibility Affects Dependent COBRA Coverage

The tables below outline how you and your Dependents' COBRA coverage is impacted if you become entitled to Medicare. (Note that for this purpose becoming entitled to Medicare means you actually become enrolled in any type of Medicare coverage, e.g. Medicare Part A, B, or D, whether because of automatic enrollment, e.g. by collecting Social Security retirement benefits, or by you choosing to voluntarily enroll in Medicare.)

For Yourself

If	Then
You are covered as an active employee[4] and become entitled to Medicare	You may not elect COBRA *(enrolling in Medicare does not cause a loss of coverage under the plan and therefore will not trigger COBRA)*
You are covered as a qualified retiree and you reach age 65	You may not elect COBRA *(entitlement to Medicare is not a COBRA triggering event for you)*
You become entitled to Medicare *after* electing COBRA continuation coverage	Your COBRA coverage will end
You become entitled to Medicare *before* electing COBRA continuation coverage	Your COBRA coverage may continue for the normal duration listed in the previous chart

For Your Spouse and Child(ren) Enrolled on the Plan

If	Then
You are covered as an active employee[4] and become entitled to Medicare	You may not elect COBRA for your spouse and child(ren) *(enrolling in Medicare does not cause a loss of coverage under the plan and therefore will not trigger COBRA)*
You are covered as an active employee[4], become entitled to Medicare and you then terminate employment or experience a reduction of hours less than 18 months after your Medicare entitlement	You may elect COBRA for your spouse and child(ren) for a period of 36 months from the date of your Medicare entitlement
You are covered as an active employee[4], become entitled to Medicare and you then terminate employment or experience a reduction of hours 18 or more months after your Medicare entitlement	You may elect COBRA for your spouse and child(ren) for a period of 18 months from the date of your termination of employment or reduction in hours
You are covered as a qualified retiree and you reach age 65	You may elect COBRA for your spouse and child(ren) for a period of 36 months
Your spouse or child(ren) become entitled to Medicare *after* election COBRA continuation coverage	Your spouse or child(ren)'s COBRA coverage will end
Your spouse or child(ren) become entitled to Medicare before electing COBRA continuation coverage	Your spouse or child(ren)'s COBRA coverage may continue for the normal duration listed in the chart above

[4]An active employee means an individual currently employed by Bellin and enrolled on the plan other than as a qualified retiree, COBRA qualified beneficiary or Dependent of another employee.

2. Earlier Termination

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

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

3. Election of Continuation Coverage

a. If you wish to continue group coverage as shown above, you must complete enrollment with Employer's COBRA Administrator.

b. You will be notified by mail if you are eligible for COBRA coverage. The notification will come from the Employer's COBRA Administrator and will give you instructions for electing COBRA coverage and advise you of the monthly cost. You will have up to 60 days from the date you receive the notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended. 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 or COBRA Administrator 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:

Bellin Memorial Hospital dba Bellin Health Systems, Inc.
Attn: Human Resources
744 South Webster Avenue
Green Bay, WI 54305

Notices may also be emailed to humanresourceinsurance@bellin.org

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

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 is180 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.

5. **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.

6. **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. HRA CLAIM PAYMENT

Expenses and supporting documentation submitted after March 31, 2019 will not be eligible for reimbursement under your HRA, except as provided in the Proof of Loss section above if the Plan is discontinued or if HPAI ceases to act as the Plan Manager.

Automatic Claims Submission. After your claim is processed for payment under the medical benefits as described in this SPD, any eligible expenses will be sent automatically to your HRA for payment consideration. Claims are paid based on the amount initially submitted. If the amount of the original claim later changes you must notify HealthPartners so that the claim can be adjusted.

You may opt out of automatic claims submission at any time if you do not wish for claims from the medical plan to be automatically submitted to your HRA for reimbursement.

You MUST opt out of automatic claims submission if either of the following is true:

1. **You have dual health plan coverage through a spouse.** In these instances reimbursement out of the HRA would not be appropriate if the claim may be paid by another source.

2. **You have a dependent covered under your health plan who does not qualify as a dependent under the Internal Revenue Code Section 152.** Reimbursement out of the HRA for dependents who meet the definition of dependent under the health plan, but not IRC Code section 152 are not allowable.

Automatic Claims Submission Forms are available on-line at www.healthpartners.com/bellin or by calling Member Services.

If you opt out of the automatic claim submission to your HRA, you must submit a manual claim for your eligible expenses in order to receive reimbursement from your HRA.

Claims paid using HRA funds will be paid directly to your provider. If there are not enough funds in the HRA to cover the expense the provider will bill you directly.

Manual Claims Submission. To receive reimbursement, you must submit a claim to your HRA for payment consideration. All claims must include a completed Health Care Expense Claim Form, including any required supporting documentation. Health Care Expense Claim Forms can be obtained online at healthpartners.com or by calling Member Services. Claims are paid based on the amount initially submitted. If the amount of the original claim later changes you must notify HealthPartners so that the claim can be adjusted.

To receive reimbursement from your HRA, claims may be submitted in one of the following ways:

- **Mobile –** Download the **myHP** app to upload and submit a Health Care Expense Claim Form or supporting documents; or

- **Online –** Log on to your account at healthpartners.com

- **Fax** a claim form and supporting documentation to HealthPartners at 952-883-5026 or 877-624-2287 (toll-free); or

- **Mail** a claim form and supporting documentation to HealthPartners at:

  HealthPartners Service Center
  CDHP – Mail Route 21104T
  P.O. Box 297
  Minneapolis, MN 55440-0297

Supporting documentation includes at least one of the following:

- Explanation of Benefits– the statement you receive each time a claim is submitted to your health plan.
- An itemized statement from the provider. The statement must show the provider name and address, patient name, date of service(s), description of service(s), and itemized charges.

You will be notified when your HRA balance reaches zero. At that time, you will be given your appeal options in the event that you believe that the determination was not correct. However, you will not be further notified, for the remainder of the calendar year, that your account balance has reached zero. If, at any time, you have questions about your account balance, please call Member Services at 952-883-7000 or 866-443-9352 (toll-free).

If it is later determined that you received an overpayment or a payment was made in error, the Plan reserves the right to require a refund or to offset future reimbursement equal to the overpayment or erroneous payment.

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

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

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.

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

If your request to CareCheck® for pre-certification is wholly or partially denied, you are entitled to appeal that decision. Your Plan provides for two levels of appeal to the named fiduciary of your Plan or its delegate. You may also have the right to an external review as described below. You must exhaust the first and second levels of the appeal process prior to bringing a civil action under section 502(a) of ERISA. The steps in this appeal process are outlined below.

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

   Member Services Department
   HealthPartners, 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 health care provider may request an expedited appeal either orally or in writing. Within 72 hours of such request, a decision on your appeal will be made.

- If the claim being appealed is for non-urgent services, a decision on your appeal will be made within 15 days.

The time periods may be extended if you agree.

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

All notifications described above will comply with applicable law.

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

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

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

- If the claim being appealed is for non-urgent services, a decision on your appeal will be made within 15 days.

The time periods may be extended if you agree.

All notifications described above will comply with applicable law.

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

If your post-service claim for benefits under the Plan is wholly or partially denied, you are entitled to appeal that decision. Your Plan provides for two levels of appeal to the named fiduciary of your Plan or its delegate. You may also have the right to an external review as described below. You must exhaust the first and second levels of the appeal process prior to bringing a civil action under section 502(a) of ERISA. The steps in this appeal process are outlined below.

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

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

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

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

The time periods may be extended if you agree.

All notifications described above will comply with applicable law.

G. EXTERNAL REVIEW PROCEDURES. You or your authorized representative must request an external review within four months of the adverse decision. If your claim is denied because of an adverse benefit determination, you have the right to request an external review, as described below.

An adverse benefit determination is a denial, reduction, or termination of, or failure to provide or make payment for a benefit for any of the following reasons:

- Failure to provide or make payment for a benefit based on a utilization review.
- Failure to provide or make payment for a benefit based on a determination that the benefit is experimental or investigational.

In addition, an adverse benefit determination includes a rescission of coverage. A rescission is a discontinuance or cancellation of coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission if it is effective retroactively because of a failure to pay premiums or contributions on a timely basis.

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

HEALTH PLAN WELLNESS REWARDS

Qualify for a lower premium and Personal Benefit Account (PBA) dollars from Bellin to offset the cost of your annual health plan deductible.

Here's how:

1

You and your spouse (if enrolling on your health plan) complete a Health Risk Assessment (HRA) within 30 days of date of hire/eligibility. *See "Free Health Risk Assessment" information available on BellinBenefits.org, New Hires page for details regarding how to schedule your HRA.* ***Note:*** *HRAs must be completed at the Green Bay HRA Clinic or by contacting one of the locations shown on the HRA information sheet available on BellinBenefits.org.*

2

You and your spouse (if enrolling on your health plan) show you are up-to-date with preventive screenings shown on the Wellness Statement by providing a Wellness Statement* completed by your Primary Care Provider's office within 90 days of date of hire/eligibility.

*No appointment is necessary if you are currently up-to-date with your preventive screenings.

If you need a screening, make an appointment with your Bellin PCP (or Tier 1 or Tier 2 in-network provider for 2018) to have the screening(s) completed after your insurance becomes effective and bring the form to your appointment. If you are enrolled on Bellin's Health Plan, the preventive screenings on the Wellness Statement are covered at 100%, if completed with a Bellin PCP or Tier 1 or Tier 2 in-network provider.

Wellness Statement is also available at BellinBenefits.org on the New Hires page, the Medical page and also on the Forms/Resources page (under Medical).

WELLNESS REWARDS

After Human Resources confirms you and your spouse (if applicable) completed the HRA and are up-to-date with the applicable preventive screenings indicated on the Wellness Statement you will qualify for a 2018 PBA Contribution from Bellin and be moved to a lower premium level for the current plan year: Bronze, Silver or Gold premium level based on your HRA score and your spouse's score, (if applicable), lowest score will be used. Employees will be moved into the appropriate premium level retroactively to the effective date of insurance.

PBA contribution: Single (employee only) = $ 550 Employee + 1 or Family = $1,100

Amounts shown are for calendar year and are prorated if participant is not enrolled on January 1st.

3

In addition, you and/or your spouse (if applicable) can complete a **Reasonable Alternative Standard (RAS)** activity to earn back HRA points lost and move from the Bronze or Silver premium level to the Silver or Gold premium level. Information is available at BellinBenefits.org, click on the "Reasonable Alternative Standard (RAS)" box.

Questions regarding the Health Plan Wellness Rewards Program?
Email: HumanResourceInsurance@bellin.org or call (920) 445-7240.

Go to **BellinBenefits.org** for information about Bellin's benefits.

bellinhealth

Health Plan Wellness Rewards: Step 3

REASONABLE ALTERNATIVE STANDARD

What is a Reasonable Alternative Standard (RAS)?

Under Bellin's Wellness Plan, the health plan premium levels are based on the outcome of the participant's Health Risk Assessment (HRA) score. This is considered an "outcome-based" wellness program. In accordance with requirements of the Health Care Reform Act, the Wellness Plan has established the Reasonable Alternative Standard (RAS) program, which is available to participants that completed the HRA and lost points on their HRA. Participants that have completed the HRA and Wellness Statement (or Consent Form) to show they are up-do-date with preventive screenings, and are in the Bronze or Silver premium level may choose to complete one or more RAS(s) activities to earn back HRA points in order to qualify for the Silver or Gold premium levels. Participants may choose to complete multiple RAS activities in order to move one or two premium levels (i.e., from Silver up to Gold or Bronze up to Gold). Upon completion of the RAS, if enough points are gained back, the employee (and spouse, if applicable) will be moved to the Silver or Gold premium level and will receive a premium refund based on the difference between the starting premium level and new premium level for premiums already paid for the current year.

A RAS is an activity that must be completed in order to earn back HRA points. There are three (3) categories of RAS Activities based on the HRA scoring: **RAS Categories**

1) Weight/BMI **2) Blood Pressure/Cholesterol/Triglycerides/Glucose** **3) Nicotine Use**

There are multiple activities the participant may choose from under each RAS category, and at least one option under each is a cost-free option. Only one of the activities under each RAS category will need to be completed to earn back points, and the number of RAS activities employee/spouse must complete for employee to move to the Silver or Gold premium level will depend on where points were lost on the HRA. For example, if an employee lost points for Weight and Blood Pressure, they would need to complete one RAS activity from each of those two RAS categories shown above to gain all of those points back.

Participants may meet with a Bellin Personal Health Coach to review HRA results and determine the category and number of RAS Activities they will need to complete in order to earn back enough HRA points to move to desired premium level (Silver or Gold). Please contact Sandy Treichel at sandra.treichel@bellin.org or Sharon Maon at sharon.maon@bellin.org to set up an appointment.

Participants will receive a RAS Certificate of Achievement (from the leader of the RAS Activity) after they have completed the activity and will need to forward their RAS Certificate to Healics to be processed (information on Certificate).

Important Information About RAS Activites:

- Employee must be in the Bronze or Silver premium level (have complete the HRA and Wellness Statement or Consent Form) to be eligible to earn back HRA points using a RAS (employees/spouses in Base level are not eligible).
- The length of all RAS activities is approximately 3 months (must be consecutive).
- Employee/Spouse must complete the RAS activity by attending the required sessions during the 3-month period in order to receive a Certificate of Achievement.
- The Certificate of Achievement will be provided to you by the individual leading your RAS activity at the completion of the RAS activity.
- The Completed Certificate of Achievement should be sent to Healics (follow instructions on RAS Certificate of Achievement). Employee/spouses should also keep a copy of the Certificate of Achievement.
- Once the information is received by Healics, if employee/spouse have earned back enough points to move them to the Silver or Gold premium level, Healics will notify Human Resource Management (HRM) of the change in premium level. HRM will move the employee* to the lower premium level (Silver or Gold) and employee will receive a premium refund for the difference in premiums between the level the employee started in (Bronze or Silver) and the new level (Silver or Gold), that have already been paid retroactive to January 1 of current year (or date insurance was effective during current year).

  **Employee and spouse (if enrolled) must both qualify for the lower premium level in order for employee to be moved to the lower premium level.*
- RAS Activities for the plan year may be completed at any time between January 1 and December 1, and employee will receive a premium refund retroactive to January 1 (or date insurance was effective). (RAS activity for the next plan year may be started beginning in October of the previous year).
- Premium refunds will be processed as soon as administratively possible, no less than the one pay period of each month.

- You may complete more than one RAS activity at the same time. However, if the same activity is completed for more than one type of RAS category, you must complete a separate session for each RAS category. For example, if you choose the Health Coach Sessions for your RAS activity for Weight/BMI and also for Cholesterol, you would need to attend 6 months of Health Coach Sessions (3 months for each RAS category).
- Both Employee and Spouse must qualify for the same premium level by completing a RAS (if necessary) in order to "Jump Up" to the Silver or Gold premium Level. (For example: If employee completes RAS and qualifies for Gold premium level, but Spouse is in the Silver premium level and does not complete a RAS, employee will stay in Silver premium level.

A list of the current RAS Activities and the instructions about how to complete a RAS Activity are available to employees on BellinBenefits.org on the Reasonable Alternative Standard (RAS) page.