HealthPartners

www.healthpartners.com/pshb

844-440-1900
TTY: 711

HealthPartners® **2025**

A Health Maintenance Organization (High and Standard Option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details.

This plan is accredited. See page 13.

Serving: the entire state of Minnesota, entire state of Iowa, parts of Wisconsin, eastern North Dakota, and eastern South Dakota.

IMPORTANT
- Rates: Back Cover
- Changes for 2025: Page 16
- Summary of Benefits: Page 110

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 13 for requirements.

Only Postal Employees and Annuitants may enroll in this plan.

HealthPartners has been awarded "Excellent" Accreditation for most of its commercial HMO and Medicare Advantage plans from the National Committee for Quality Assurance (NCQA). NCQA is an independent, not-for-profit organization dedicated to measuring the quality of America's healthcare.

Enrollment codes for this Plan:

KGA High Option – Self Only
KGC High Option – Self Plus One
KGB High Option – Self and Family
KGD Standard Option – Self Only
KGF Standard Option – Self Plus One
KGE Standard Option - Self and Family

PSHB

Authorized for distribution by the:

United States
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Healthcare and Insurance
http://www.opm.gov/insure

RI - 73-915

Important Notice for Medicare-eligible Active Employees from HealthPartners
About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the HealthPartners High Option and Standard Option prescription drug benefit coverage for active employees is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all Plan participants and is considered Creditable Coverage. This means active employees and their covered family members do not need to enroll in an open market Medicare Part D plan and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your PSHB coverage as an active employee.

However, if you (as an active employee and your covered Medicare Part D-eligible family members) choose to enroll in an open market Medicare Part D plan, you can keep your PSHB coverage and your PSHB plan will coordinate benefits with Medicare.

Please be advised

If you lose or drop your PSHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213 TTY 800-325-0778.

Additional Premium for Medicare's High Income Members
Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your PSHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return**. You do not make any IRMAA payments to your PSHB plan. Refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

You can get more information about open market Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, TTY 877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of the HealthPartners High Option and the HealthPartners Standard Option Plan under contract (CS 2875) between HealthPartners, as a legal entity, and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits (FEHB) law, as amended by the Postal Service Reform Act, which created the Postal Service Health Benefits (PSHB) Program. Customer service may be reached at 844-440-1900 (TTY: 711) or through our website: www.healthpartners.com/pshb. The address for HealthPartners administrative office is: 8170 33rd Avenue South, Bloomington, MN 55425.

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. If you are a Postal Service annuitant and you are eligible for Medicare Part D, or a covered Medicare Part D-eligible family member of a Postal Service annuitant, your prescription drug benefits are provided under our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP). You do not have a right to benefits that were available before January 1, 2025, under the FEHB Program unless those benefits are also shown in this PSHB Plan brochure.

OPM negotiates benefits and rates for each plan annually. Benefits are effective January 1, 2025. Rates are shown at the end of this brochure.

Plain Language

All PSHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee and each covered family member, "we" means HealthPartners.
- We limit acronyms to ones you know. OPM is the United States Office of Personnel Management. The FEHB Program is the Federal Employees Health Benefits Program administered by OPM and established under 5 U.S.C. chapter 89. The PSHB Program is the Postal Service Health Benefits Program established within the FEHB Program under 5 U.S.C. section 8903c. PSHB Plan means a health benefits plan offered under the PSHB Program. PSHB means Postal Service Health Benefits. If we use others, we tell you what they mean.
- Our brochure and other PSHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Healthcare Fraud!

Fraud increases the cost of healthcare for everyone and increases your Postal Service Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the PSHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.

- If the provider does not resolve the matter, call us at 844-440-1900 and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE
877-499-7295
OR go towww.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/
The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.
You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

Do not maintain family members on your policy:

- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
- Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26)

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain PSHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, for example a member's gender identity or the fact that the covered benefit is sought in connection with gender-affirming care, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable death within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider’s portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.

- www.jointcommission.org/speakup.aspx. The Joint Commission’s Speak Up™ patient safety program.

- www.ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.

- https://psnet.ahrq.gov/issue/national-patient-safety-foundation The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.

- www.bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.

- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions (“Never Events”)

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called “Never Events” or “Serious Reportable Events.”

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your PSHB plan will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct Never Events, if you use HealthPartners Open Access Network preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

Coverage information

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the PSHB Program**

See https://health-benefits.opm.gov/PSHB/ for enrollment information as well as:

- Information on the PSHB Program and plans available to you
- A health plan comparison tool

Note: Contact the USPS for information on how to enroll in a PSHB Program Plan through the PSHB System.

Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your PSHB coverage. These materials tell you:

- When you may change your enrollment
- How you can cover your family members
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
- What happens when your enrollment ends
- When the next Open Season for enrollment begins

We do not determine who is eligible for coverage. You will be responsible for making changes to your enrollment status through the PSHB System. In some cases, your employing or retirement office may need to submit documentation. For information on your premium deductions, you must also contact your employing or retirement office.

Once enrolled in your PSHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member.

You enroll in a PSHB Program Plan and make enrollment changes in the PSHB System located at https://health-benefits.opm.gov/PSHB/. For assistance with the PSHB System, call the PSHB Helpline at 844-451-1261. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment request. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

Use the PSHB System if you want to change from Self Only to Self Plus One or Self and Family, and to add or remove a family member.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive benefits. Please report changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26 through the PSHB System. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one PSHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another PSHB or FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the PSHB Program, change your enrollment, or cancel coverage using the PSHB System. For a complete list of QLEs, visit the PSHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, personnel/payroll office, or retirement office.

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member, as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the PSHB Program if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no PSHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the PSHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for PSHB coverage, you must continue your PSHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

For annuitants who are required to be enrolled in Medicare Part B as a condition to continue PSHB coverage in retirement: If you enroll in Medicare Part B and continue PSHB coverage in retirement, the child equity law applies to you and you cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your child(ren) live as long as the court/administrative order is in effect. You cannot be compelled to enroll or remain enrolled in Medicare Part B to maintain your PSHB enrollment as a condition to satisfy a court/administrative order. However, if you do not enroll (or remain enrolled) in Medicare Part B as required to continue your PSHB coverage in retirement (notwithstanding an existing court/administrative order), you will not be able to continue your PSHB coverage in retirement.

- **Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP)**

Our PDP EGWP is only available to Postal Service annuitants who are Medicare Part D-eligible and their covered Medicare Part D-eligible family members. Our PDP EGWP is not an open market Medicare Part D Plan. If you are an active Postal Service employee, or covered family member, and become eligible to enroll in Medicare Part D, you are not eligible to enroll in our PDP EGWP. Please, contact CMS for assistance at 800-MEDICARE (800-633-4227).

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage and premiums begin on January 1. If you joined at any other time during the year, your employing or retirement office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the PSHB Program. Generally, you must have been enrolled in the FEHB and/or PSHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When PSHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

If you are eligible for coverage under spouse equity, you are only eligible to enroll in the FEHB Program. If you are not eligible for coverage under spouse equity and you are otherwise eligible for Temporary Continuation of Coverage (TCC), then you could enroll in TCC under the PSHB Program.

- **Upon divorce**

If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must enter the date of the divorce or annulment and remove your ex-spouse in the PSHB System. We may ask for a copy of the divorce decree as proof. If you need to change your enrollment type, you must use the PSHB System. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). Former spouses eligible for coverage under the spouse equity law are not eligible to enroll in the PSHB Program. However, former spouses eligible for coverage under the spouse equity law may enroll in the FEHB Program. (Former Spouses seeking but not yet adjudicated as eligible for Spouse Equity may be entitled to TCC under a PSHB plan in the interim).

Former spouses not meeting the spouse equity requirements may be eligible for TCC under the PSHB Program provided you otherwise meet the eligibility requirements for TCC. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

- **Medicare PDP EGWP**

When a Postal Service annuitant who is Medicare Part D-eligible or their covered Medicare-eligible family member opts out of or disenrolls from our PDP EGWP, they will not have our prescription drug coverage under this plan. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for additional information at 844-440-1900.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your PSHB enrollment after you retire, if you lose your Federal job, or if you are a covered child and you turn 26.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing PSHB Program coverage.

- **Converting to individual coverage**

You may convert to a non-PSHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must contact us in writing within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the PSHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 844-440-1900 or visit our website at www.healthpartners.com/pshb.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that PSHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. HealthPartners holds the following accreditation: "Excellent" accreditation from the National Committee for Quality Assurance (NCQA). To learn more about this plan's accreditation, please visit www.ncqa.org. We generally require you to see specific physicians, hospitals and other providers that contract with us. These Plan providers coordinate your healthcare services. We are solely responsible for the selection of these providers. Contact us for a copy of our most recent provider directory. There is one provider directory for both Plan options. We give you a choice of enrollment in a High Option or a Standard Option.

The plans emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from the Plan's Open Access Network providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance and deductibles described in this brochure. When you receive emergency services from non-plan providers and when you use the out-of-network benefit of Standard Option, you may have to submit claim forms.

You should join an HMO because you prefer the Plan's benefits, not because a particular provider is available. You cannot change Plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

Our network is subject to change. For the most current information on the network, visit our website at www.healthpartners.com/pshb or call us at 844-440-1900 (TTY: 711).

General features of our High and Standard Options

The Plan lets you receive care from a large network of providers. Referrals are not required and you do not need to choose a primary care clinic. Any time you or a member in your family needs care, you may choose to see any provider in this Network. With limited exceptions, if you seek care from a provider who does not participate in the Network, your care is considered out-of-network and may not be covered. Standard Option lets you obtain care in the Open Access Network or out-of-network.

We have Open Access benefits

The plans offer Open Access benefits. This means you can receive covered services from a HealthPartners Open Access Network participating provider without a required referral from your primary care provider or another participating provider in the network.

How we pay providers

We contract with individual physicians, medical groups and hospitals to provide the Open Access Network benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies). Out-of-network providers have not agreed to negotiated fees and you may be responsible for amounts above usual and customary levels.

Preventive care services

Preventive care services are generally covered with no cost sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Annual deductible

On the Standard Option plan: The annual deductible must be met before Plan benefits are paid for care other than preventive care services, generic drugs, or your five free office visits.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than $9,200 for Self Only enrollment, and $18,400 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount. See page 102 if you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).

Health education resources and accounts management tools

Learn more about our health education resources in Section 5(h) Wellness and Other Special Features.

Your rights and responsibilities

OPM requires that all PSHB plans provide certain information to their PSHB members. You may get information about us, our networks, our providers and facilities. OPM's PSHB website www.opm.gov/healthcare-insurance/ lists the specific types of information that we must make available to you. Some of the required information is listed below:

- HealthPartners is Minnesota's only consumer-governed health Plan. Our Board of Directors is composed of consumer-elected members. HealthPartners is a licensed HMO in the State of Minnesota.
- Information on the following topics is available by calling HealthPartners Member Services:
  - Details on your health plan benefits, claims and account balances
  - Assistance finding and choosing a provider in your network
  - Prescription drug information specific to your benefits
  - A warm transfer to HealthPartners Nurse Navigator program staffed by experience nurses who help research treatment options, coordinate care and guide you through difficult decisions
- Member Services representatives are available from 8 a.m. until 6 p.m., Monday through Friday, Central Standard Time.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, www.healthpartners.com/pshb. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 844-440-1900 (TTY: 711), or write to HealthPartners, PO Box 21662, Eagan, MN 55121. You may also visit our website at www.healthpartners.com/pshb.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.healthpartners.com/pshb to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is:

The following counties in Minnesota (includes all counties in Minnesota): Aitkin, Anoka, Becker, Beltrami, Benton, Big Stone, Blue Earth, Brown, Carlton, Carver, Cass, Chippewa, Chisago, Clay, Clearwater, Cook, Cottonwood, Crow Wing, Dakota, Dodge, Douglas, Faribault, Fillmore, Freeborn, Goodhue, Grant, Hennepin, Houston, Hubbard, Isanti, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahnomen, Marshall, Martin, McLeod, Meeker, Mille Lacs, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pennington, Pine, Pipestone, Polk, Pope, Ramsey, Red Lake, Redwood, Renville, Rice, Rock, Roseau, Saint Louis, Scott, Sherburne, Sibley, Stearns, Steele, Stevens, Swift, Todd, Traverse, Wabasha, Wadena, Waseca, Washington, Watonwan, Wilkin, Winona, Wright and Yellow Medicine.

The following counties in Iowa (includes all counties in Iowa): Adair, Adams, Allamakee, Appanoose, Audubon, Benton, Black Hawk, Boone, Bremer, Buchanan, Buena Vista, Butler, Calhoun, Carroll, Cass, Cedar, Cerro Gordo, Cherokee, Chickasaw, Clarke, Clay, Clayton, Clinton, Crawford, Dallas, Davis, Decatur, Delaware, Des Moines, Dickinson, Dubuque, Emmet, Fayette, Floyd, Franklin, Fremont, Greene, Grundy, Guthrie, Hamilton, Hancock, Hardin, Harrison, Henry, Howard, Humboldt, Ida, Iowa, Jackson, Jasper, Jefferson, Johnson, Jones, Keokuk, Kossuth, Lee, Linn, Louisa, Lucas, Lyon, Madison, Mahaska, Marion, Marshall, Mills, Mitchell, Monona, Monroe, Montgomery, Muscatine, O'Brien, Osceola, Page, Palo Alto, Plymouth, Pocahontas, Polk, Pottawattamie, Poweshiek, Ringgold, Sac, Scott, Shelby, Sioux, Story, Tama, Taylor, Union, Van Buren, Wapello, Warren, Washington, Wayne, Webster, Winnebago, Winneshiek, Woodbury, Worth and Wright.

The following counties in North Dakota: Adams, Barnes, Benson, Bottineau, Bowman, Burleigh, Cass, Cavalier, Dickey, Eddy, Emmons, Foster, Grand Forks, Grant, Griggs, Hettinger, Kidder, LaMoure, Logan, McHenry, McIntosh, McLean, Mercer, Morton, Mountrail, Nelson, Pembina, Pierce, Ramsey, Ransom, Renville, Richland, Rolette, Sargent, Sheridan, Sioux, Stark, Steele, Stutsman, Towner, Traill, Walsh, Ward and Wells.

The following counties in South Dakota: Aurora, Beadle, Bon Homme, Brookings, Brown, Brule, Butte, Campbell, Charles Mix, Clark, Clay, Codington, Corson, Custer, Davison, Day, Deuel, Douglas, Edmunds, Faulk, Grant, Gregory, Hamlin, Hand, Hanson, Harding, Hughes, Hutchinson, Hyde, Jerauld, Jones, Kingsbury, Lake, Lawrence, Lincoln, Lyman, Marshall, McCook, McPherson, Meade, Miner, Minnehaha, Moody, Pennington, Perkins, Potter, Roberts, Sanborn, Spink, Tripp, Turner, Union, Walworth and Yankton.

The following counties in Wisconsin: Adams, Ashland, Barron, Bayfield, Brown, Buffalo, Burnett, Calumet, Chippewa, Clark, Crawford, Douglas, Dunn, Eau Claire, Florence, Forest, Grant, Green Lake, Iron, Jackson, Juneau, Kewaunee, La Crosse, Langlade, Lincoln, Manitowoc, Marathon, Marinette, Marquette, Menominee, Monroe, Oconto, Oneida, Outagamie, Pepin, Pierce, Polk, Portage, Price, Richland, Rusk, Sauk, Sawyer, Shawano, St. Croix, Taylor, Trempealeau, Vernon, Vilas, Washburn, Waupaca, Waushara, Winnebago and Wood.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other healthcare services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2025

This is the first year for the Postal Service Health Benefits Program (PSHBP). This Section is not an official statement of benefits. For that, go to Section 5. Benefits.

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the PSHB System enrollment confirmation. Note: If you are enrolled in our Medicare Part D PDP EGWP, you may receive a second ID card for your prescription drug benefits.

If you do not receive your ID card within 30 days after the effective date of your enrollment or if you need replacement cards, call us at 844-440-1900 (TTY: 711) or write to us at Riverview Member Services, PO Box 21662, Eagan, MN 55121. You may also request replacement cards through our website at www.healthpartners.com/pshb.

Where you get covered care

In-Network: You get care from "Plan providers" and "Plan facilities." You will pay copayments, deductibles, and/or coinsurance. You can receive covered services from a participating provider without a referral from your primary care provider or another participating provider in the network.

Out-of-Network (Standard Option): You may choose to use your out-of-network benefits and receive care from any licensed provider. You may be billed for these services and may need to file a claim for reimbursement.

Balance Billing Protection

PSHB Carriers must have clauses in their in-network (participating) provider agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in-network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

Plan providers

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to national standards.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

We list Plan providers in the HealthPartners Open Access Network provider directory, which we update periodically. For information that is updated weekly, visit www.healthpartners.com/pshb.

This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

This plan provides Care Coordinators for complex conditions and can be reached at 952-883-5469 or 800-871-9243 for assistance.

This Plan lets you receive care from more than 850,000 providers in the Open Access Network. Referrals are not required and you do not need to choose a primary care clinic. Any time you or a member in your family needs care, you may choose to see any provider in this network.

High Option: With limited exceptions, if you seek care from a provider who does not participate in the Open Access Network, your care is considered out-of-network and may not be covered.

Standard Option: With limited exceptions, if you seek care from a provider who does not participate in the Open Access Network, your care is considered out-of-network and the lower out-of-network benefits apply.

Plan facilities

Plan facilities are hospitals and other facilities that we contract with to provide covered services to our members. We list these in the Open Access Network provider directory, which we update periodically. The list is on our website: www.healthpartners.com/pshb.

High Option: With limited exceptions, if you seek care from a facility that does not participate in the Open Access Network, your care is considered out-of-network and may not be covered.

Standard Option: With limited exceptions, if you seek care from a facility that does not participate in the Open Access Network, your care is considered out-of-network and the lower out-of-network benefits apply.

What you must do to get covered care

High Option: Any time you or a member in your family needs care, you should choose to see any provider in the Open Access Network. With limited exceptions, if you seek care from a provider who does not participate in the Network your care is considered out-of-network and may not be covered.

Standard Option: Any time you or a member in your family needs care, you should choose to see any provider in the Open Access Network. You may choose to use your out-of-network benefit and receive care from any licensed provider. You may be billed for these services and may need to file a claim for reimbursement.

- **Primary care**

Members are not required to pick a primary clinic. However, we encourage members to work with personal physicians who will get to know them. Primary care providers are providers in the following categories: family and general practice, internal medicine, pediatrics, adolescent medicine, adult medicine and geriatrics. Your primary care provider will provide most of your healthcare or suggest that you see a specialist. You can see any specialist without a referral.

If you want to change your primary care provider or if your primary care provider leaves the Plan, simply choose another provider from the Open Access Network directory for in-network benefits. For the most up-to-date network provider information, visit www.healthpartners.com/pshb, where information is updated weekly.

- **Specialty care**

Specialty care providers are providers who are not in the following categories: family and general practice, internal medicine, pediatrics, adolescent medicine, adult medicine and geriatrics.

You have direct access to any specialist in the Open Access Network without a referral.

If you are seeing a specialist when you enroll in our Plan and your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

If you are seeing a specialist and your specialist leaves the Plan, you may be able to continue seeing your provider for a period of time, please see Continuity of care for more information.

- **Continuity of care**

If you are seeing a provider when you enroll in our Plan and your current provider does not participate with us, you must receive treatment from a provider who does. Generally, we will not pay for you to see a provider who does not participate with our Plan. However, in the event you must change your current primary care provider, specialty care provider or general hospital provider because that provider leaves the Open Access Network, HealthPartners drops out of the Postal Service Employees Health Benefits (PSHB) Program and you enroll in another PSHB plan; or HealthPartners reduces our Service Area and you enroll in another PSHB plan, you may be able to continue seeing your provider for a period of time. Some services provided by out-of-network providers may be considered a covered benefit for up to 120 days under this Plan if you qualify for continuity of care benefits under state or federal law.

Conditions that qualify for this benefit are:

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

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

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

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

Call Member Services for further information regarding continuity of care benefits, or if we drop out of the Program, contact your new plan.

- **Designated providers**

You may be required to see a designated provider for transplants and bariatric surgery. A designated provider is a healthcare provider, group or association of healthcare providers designated by us to provide services, supplies or drugs for specified transplants or bariatric surgery.

- **Hospital care**

Your primary care provider or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call HealthPartners Member Services immediately at 844-440-1900 (TTY: 711). If you are new to the PSHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to this PSHB plan, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the PSHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member’s benefits under the new plan begin on the effective date of enrollment.

- **Determination of coverage**

We cover eligible services only when medically necessary for the proper treatment of a member. Our 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. Coverage determinations are based on the terms of this brochure and our coverage criteria policies, which are subject to periodic review and modification by the medical or dental directors. Coverage determinations for prescription drugs are based on requirements established by the HealthPartners Pharmacy and Therapeutics Committee, and are subject to periodic review and modification.

You need prior Plan approval for certain services

Since your primary care provider arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under Other services.

You must get prior approval for certain services.

- **Inpatient hospital admission**

Prior-authorization is the process by which -- prior to your inpatient hospital admission -- we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care provider has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary and follows generally accepted medical practice.

We call this review and approval process prior authorization. Your physician must obtain prior authorization for services such as:

- Reconstructive surgery
- Promising therapies/new technologies
- Transplants
- Medically necessary dental care, such as orthognathic surgery
- Durable medical equipment and prosthetics
- Home health care
- Skilled nursing care
- Hospice care
- Habilitative therapy
- Bariatric surgery
- Growth hormone therapy (GHT)
- Gender affirming (confirmation) surgery

The complete list, along with the criteria we use to review authorization requests, is available on www.healthpartners.com/pshb or by calling HealthPartners Member Services at 844-440-1900 (TTY: 711). Your physician is responsible for obtaining prior authorization.

How to request for an admission or get prior authorization for other services

First your physician, your hospital, you, or your representative, must call us at 952-883-6333 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- Enrollee's name and Plan identification number
- Patient's name, birth date, identification number and phone number
- Reason for hospitalization, proposed treatment, or surgery
- Name and phone number of admitting physician
- Name of hospital or facility
- Number of days requested for hospital stay

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 844-440-1900 (TTY: 711). You may also call OPM's Postal Service Insurance Operations (PSIO) at 202-936-0002 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 844-440-1900 (TTY: 711). If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must phone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

Inpatient delivery does not require precertification or prior authorization from us. You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 72 hours after we receive the claim.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 844-440-1900.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Note: If you are enrolled in our Medicare PDP EGWP and do not agree with our benefit coverage decision you have the right to appeal. See Section 8(a) of this brochure and Chapter 7 of the Prescription Drug Plan Evidence of Coverage for information about the PDP EGWP appeal process.

Section 4. Your Cost for Covered Services

This is what you will pay out-of-pocket for covered care:

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance and copayments) for the covered care you receive.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: With High Option, when you see your primary care provider, you pay a copayment of $45 per office visit.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

Any 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 an enrollee for a product or service, will not apply toward your deductible.

High Option: The High Option plan includes a $500 calendar year deductible specific only to inpatient and outpatient hospital services and MRI/CT scans.

Standard Option:
For Network Expenses: The calendar year deductible is $750 for persons enrolled for Self Only coverage, $1,500 for persons enrolled for Self Plus One coverage and $1,500 for families enrolled for Self and Family coverage. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $750. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable to you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $1,500. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $1,500.

For Out-of-Network Expenses: The calendar year deductible is $2,000 for persons enrolled for Self Only coverage $4,000 for persons enrolled for Self Plus One coverage and $4,000 for families enrolled for Self and Family coverage. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $2,000. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable to you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $4,000. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $4,000.

Note: If you change PSHB plans during Open Season, the effective date of your new PSHB plan is January 1 of the next year, and a new deductible starts on January 1. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Coinsurance

Coinsurance is the percentage of our negotiated fee (our plan allowance) that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

Example: In our Plan, you pay 20% of our allowance for durable medical equipment.

Differences between our Plan allowance and the bill

You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum

Any 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 an enrollee for a product or service, will not apply to your catastrophic protection out-of-pocket maximum.

If you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP), the prescription drug out-of-pocket maximum is $2,000. After this maximum is met, we pay 100% of all eligible covered prescription drug benefits.

High Option: If you are enrolled for Self Only coverage, when your copayments and/or coinsurance total $6,500 in a calendar year, you do not have to pay any more for covered services for the remainder of that calendar year.

If you are enrolled for Self Plus One coverage, when you and your dependent's copayments and/or coinsurance total $13,000 in a calendar year, you and your dependent do not have to pay any more for covered services for the remainder of that calendar year. However, each enrollee will not pay more than $9,200 in a calendar year.

If you are enrolled for Self and Family coverage, when your family's copayments and/or coinsurance total $13,000 in a calendar year, you and your dependents do not have to pay any more for covered services for the remainder of that calendar year. However, each enrollee will not pay more than $9,200 in a calendar year.

Standard Option: In-Network: If you are enrolled for Self Only coverage, when your deductible, copayments and/or coinsurance total $7,500 in a calendar year, you do not have to pay any more for covered services for the remainder of that calendar year.

If you are enrolled for Self Plus One coverage, when you and your dependent's, deductible, copayments and/or coinsurance total $15,000 in a calendar year, you and your dependent do not have to pay any more for covered services for the remainder of that calendar year. However, each enrollee will not pay more than $9,200 in a calendar year.

If you are enrolled for Self and Family coverage, when your family's deductible, copayments and/or coinsurance total $15,000 in a calendar year, you and your dependents do not have to pay any more for covered services for the remainder of that calendar year. However, each enrollee will not pay more than $9,200 in a calendar year.

Out-of-Network: There is no limit on your out-of-pocket expenses.

Carryover

If you changed to this PSHB Plan during Open Season from a plan with a catastrophic protection benefit the effective date of the change is January 1, and covered expenses that apply to this plan's catastrophic protection benefit starts on January 1.

Note: If you change PSHB plans during Open Season the effective date of your new PSHB plan is January 1 of the next year, and a new catastrophic protection accumulation starts on January 1. If you change plans at another time during the year, you must begin a new catastrophic protection accumulation under your new plan.

Note: If you change options in this Plan due to a qualifying life event (QLE) during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your prior option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Government Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

In addition, your health plan adopts and complies with any state surprise billing laws, as may be applicable, in Minnesota, Wisconsin, Iowa, North Dakota, South Dakota.

Provisions of the No Surprises Act do not apply to out-of-network claims from providers that are outside of the US or US territories. Coverage level for services received outside of these areas is the same as corresponding out-of-network Benefits (if available), depending on the type of service provided.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.healthpartners.com/pshb or contact the health plan at 844-440-1900 (TTY: 711).

Section 5. High and Standard Option Benefits

Page 110 and page 112 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High and Standard Option Benefits Overview

This Plan offers both a High and a Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at 844-440-1900 (TTY: 711) on our website at www.healthpartners.com/pshb. Each option offers unique features.

High Option:

- HealthPartners' service area includes all counties in Minnesota and Iowa, parts of Wisconsin, eastern North Dakota and eastern South Dakota
- You don't need to choose a primary clinic
- You can see any network provider – primary care or specialist – without a referral
- Preventive services, including routine eye exams and hearing exams, are covered at 100%
- $250 incentive, in the form of a HealthPartners Wellness Account debit card to be used towards most qualified medical expenses, for each adult employee or spouse who completes an online health assessment and an eligible online health improvement program.

Standard Option:

- HealthPartners' service area includes all counties in Minnesota and Iowa, parts of Wisconsin, eastern North Dakota and eastern South Dakota
- You don't need to choose a primary clinic
- You can see any network provider – primary care or specialist – without a referral
- In-Network: Preventive services, including routine eye and hearing exams, are covered at 100%
- In-Network: Each year, each member's first five office visits are covered at 100%
- Deductibles apply to most services except as listed
- Generic drug copayments have no deductible
- $250 incentive, in the form of a HealthPartners Wellness Account debit card to be used towards most qualified medical expenses, for each adult employee or spouse who completes an online health assessment and an eligible online health improvement program.

Both Options - As a member of either option, you have access to:

- Worldwide emergency care
- HealthPartners' nationally recognized disease and case management programs
- National network with over 950,000 providers.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary
- To receive in-network benefits, you must use a physician in our provider network
- Be sure to read Section 4, *Your Cost for Covered Services*, for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- For you to receive in-network benefits, Plan physicians must provide your care.
- For High Option. The plan includes a $500 calendar year deductible specific only to inpatient and outpatient hospital services and MRI/CT scans.
- For Standard Option. For Network Expenses: The calendar year deductible is $750 for persons enrolled for Self Only coverage, $1,500 for persons enrolled for Self Plus One coverage and $1,500 for families enrolled for Self and Family coverage. For Out-of-Network Expenses: The calendar year deductible is $2,000 for persons enrolled for Self Only coverage, $4,000 for persons enrolled for Self Plus One coverage and $4,000 for families enrolled for Self and Family coverage. The calendar year deductible applies to almost all Standard Option benefits in this Section. We added "deductible does not apply" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, Your Cost for Covered Services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You Pay	
For Standard Option, a calendar year deductible applies to almost all benefits in this Section. We specify when it does not apply.		
Diagnostic and treatment services	**High Option**	**Standard Option**
We cover professional services of physicians: • In an office • Office medical consultations • Scheduled telephone visits • Second surgical opinion • Testing and treatment of sexually transmitted diseases and testing for HIV and HIV-related conditions provided by a Plan or non-Plan provider Note: List of qualifying clinics is available at www.healthpartners.com/pshb.	$45 per office visit If other services are performed during the visit, such as diagnostic imaging or laboratory services, additional Deductible, Copayment or Coinsurance may apply. Diagnostic imaging services and laboratory services are covered under the "Lab, X-ray and other diagnostic tests" benefit.	In-Network: $0 for the first 5 office, convenience clinic, telephone, urgent care visits, evisits and video visits combined in a calendar year (deductible does not apply), then 20% of charges, subject to the in-network deductible. Physician's services, laboratory and radiology performed in conjunction with the same visit and on the same date of service are included; however, charges for day treatment services, group visits, office procedures and other ancillary services are not included and will be subject to your deductible and coinsurance. Out-of-Network: 40% of charges after out-of-network deductible

Diagnostic and treatment services - continued on next page

Benefit Description	You Pay	
Diagnostic and treatment services (cont.)	**High Option**	**Standard Option**
• At a convenience clinic Note: For a list of convenience clinics, see your provider directory, call Member Services or visit our website at www.healthpartners.com/pshb.	$10 per office visit	In-Network: $0 for the first 5 office, convenience clinic, telephone, urgent care visits, evisits and video visits combined in a calendar year (deductible does not apply), then 20% of charges, subject to the in-network deductible. Physician's services, laboratory and radiology performed in conjunction with the same visit and on the same date of service are included; however, charges for day treatment services, group visits, office procedures and other ancillary services are not included and will be subject to your deductible and coinsurance. Out-of-Network: 40% of charges after out-of-network deductible
• E-visit or chat based visits We cover asynchronous online or mobile app encounters to discuss a patient's personal health information, vital signs, and other physiologic data or diagnostic images. The healthcare provider reviews and delivers a consultation, diagnosis, prescription or treatment plan after reviewing the patient's visit information	$10 per visit.	In-Network: $0 for the first 5 office, convenience clinic, telephone, urgent care visits, evisits and video visits combined in a calendar year (deductible does not apply), then 20% of charges, subject to the in-network deductible. Physician's services, laboratory and radiology performed in conjunction with the same visit and on the same date of service are included; however, charges for day treatment services, group visits, office procedures and other ancillary services are not included and will be subject to your deductible and coinsurance. Out-of-Network: 40% of charges after out-of-network deductible

Diagnostic and treatment services - continued on next page

Benefit Description	You Pay	
Diagnostic and treatment services (cont.)	**High Option**	**Standard Option**
• Video Visits We cover live, synchronous interactive encounters using secure web-based video between a patient and a healthcare provider.	$45 per office visit $500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of inpatient hospital charges	In-Network office visits: $0 for the first 5 office, convenience clinic, telephone, urgent care visits, evisits and video visits combined in a calendar year (deductible does not apply), then 20% of charges, subject to the in-network deductible. Physician's services, laboratory and radiology performed in conjunction with the same visit and on the same date of service are included; however, charges for day treatment services, group visits, office procedures and other ancillary services are not included and will be subject to your deductible and coinsurance. In-Network hospital visits: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
• Through Virtuwell®, our online benefits program at www.Virtuwell.com	Nothing.	Nothing.
• In an urgent care center	$45 per office visit If other services are performed during the visit, such as diagnostic imaging or laboratory services, additional Deductible, Copayment or Coinsurance may apply. Diagnostic imaging services and laboratory services are covered under the "Lab, X-ray and other diagnostic tests" benefit.	In- or Out-of-Network: $0 for the first 5 office, convenience clinic, telephone, urgent care visits, evisits and video visits combined in a calendar year (deductible does not apply), then 20% of charges, subject to the in-network deductible. Physician's services, laboratory and radiology performed in conjunction with the same visit and on the same date of service are included; however, charges for day treatment services, group visits, office procedures and other ancillary services are not included and will be subject to your deductible and coinsurance.

Diagnostic and treatment services - continued on next page

Benefit Description	You Pay	
Diagnostic and treatment services (cont.)	**High Option**	**Standard Option**
• Specialty drugs administered in an office We cover specialty drugs that are used to treat chronic health conditions including but not limited to such conditions as transplant recipients, immunological conditions, growth hormone, bleeding disorder, HIV/ AIDS. We require prior authorization for certain drugs and the site where the drug will be administered.	40% of charges	In-Network: 40% of charges, after deductible Out-of-Network: All charges
• During a hospital stay • In a skilled nursing facility	$500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of inpatient hospital charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
• At home physical therapy, occupational therapy, speech therapy, respiratory therapy and home health aide services	$45 per visit	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Outpatient professionally administered injections (other than specialty drugs)	**High Option**	**Standard Option**
• Injections administered in a Physician's office or Outpatient Facility, including professional administration of Drugs and blood products For allergy injections, see Allergy care on page 39	15% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
We cover tests, such as: • Blood tests • Urinalysis • Non-routine pap test • Pathology • Routine prostate specific antigen (PSA) testing for individuals 40 years of age or over who are symptomatic or in a high-risk category and for all individuals 50 years of age or older	$45 per visit	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
• X-ray • Non-routine mammogram • Ultrasound • Electrocardiogram and EEG	20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
• CT/CAT Scan • MRI	$500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges. The hospital deductible applies even for services received in an office.	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible

Benefit Description	You Pay	
Preventive care, adult	**High Option**	**Standard Option**
Routine physicals The **following** preventive services are covered at the time interval recommended at each of the links below. • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, all FDA approved contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at https://www.hrsa.gov/womens-guidelines • To build your personalized list of preventive services go to https://health.gov/myhealthfinder Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination that is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing	In-Network: Nothing Out-of-Network: 40% of charges after out-of-network deductible
• Routine hearing and eye exams	Nothing	In-Network: Nothing Out-of-Network: 40% of charges after out-of-network deductible
• Routine 2D and 3D mammogram	Nothing	In-Network: Nothing Out-of-Network: 40% of charges after out-of-network deductible
• Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/	Nothing	In-Network: Nothing Out-of-Network: 40% of charges after out-of-network deductible
• Tobacco use screening and interventions	Nothing	In-Network: Nothing Out-of-Network: 40% of charges after out-of-network deductible

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
We cover online account, online health assessment and online wellness courses	$250 incentive, in the form of a HealthPartners Wellness Account debit card to be used towards most qualified medical expenses, for each adult employee or covered spouse who registers for online services and completes an online health assessment and an eligible online health improvement program (Limit one incentive per adult employee or covered spouse per calendar year). Total maximum incentive amount is $250 Self and $500 Family. Additional information is available at www.healthpartners.com/pshb	$250 incentive, in the form of a HealthPartners Wellness Account debit card to be used towards most qualified medical expenses, for each adult employee or covered spouse who registers for online services and completes an online health assessment and an eligible online health improvement program (Limit one incentive per adult employee or covered spouse per calendar year). Total maximum incentive amount is $250 Self and $500 Family. Additional information is available at www.healthpartners.com/pshb
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy, including weight management classes and individual and group behavior counseling sessions as described in our Coverage Criteria available at www.healthpartners.com/public/coverage-criteria/. • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. This includes group counseling, diabetes education/classes, nutrition education/classes, community health workers, diabetes prevention and weight management as described in our Coverage Criteria available at www.healthpartners.com/public/coverage-criteria/. Notes: Also see Section 5(h) for additional nutritional and physical activity support • When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) or 5(f)(a), if applicable, for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.	Nothing	In-Network: Nothing Out-of-Network: 40% of charges after out-of-network deductible

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
Not covered: Any health services, certifications or examinations required by a third party when not otherwise medically necessary or eligible preventive care. This includes, but is not limited to, services: • To get or keep a job, including vocational assessments • Required under a labor agreement or other contract • Needed for legal proceedings. This includes, but is not limited to, services related to custody evaluations, parenting assessments, adoption studies, reports to the court, risk assessments for sexual offenses, educational classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) competency evaluations • For purposes of insurance • To get or keep a license	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Children's immunizations endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at www.cdc.gov/vaccines/schedules/index.html • You may also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination that is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing	In-Network: Nothing Out-of-Network: 40% of charges after out-of-network deductible

Preventive care, children - continued on next page

Benefit Description	You Pay	
Preventive care, children (cont.)	**High Option**	**Standard Option**
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy, including weight management classes and individual and group behavior counseling sessions as described in our Coverage Criteria available at www.healthpartners.com/public/coverage-criteria/. • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. This includes group counseling, diabetes education/classes, nutrition education/classes, community health workers, diabetes prevention and weight management as described in our Coverage Criteria available at www.healthpartners.com/public/coverage-criteria/. Notes: Also see Section 5(h) for additional nutritional and physical activity support • When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.	Nothing	In-Network: Nothing Out-of-Network: 40% of charges after out-of-network deductible
Maternity care	**High Option**	**Standard Option**
We cover complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes for pregnant individuals • Screening and counseling for prenatal and postpartum depression	Nothing for routine prenatal care, the first postpartum care visit or routine gestational diabetes screening. $45 per office visit for postpartum care visits thereafter.	In-Network: Nothing. Out-of-Network: 40% of charges after out-of-network deductible
• Delivery Note: Here are some things to keep in mind: • You do not need to prior authorize your vaginal delivery. • As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.	$500 hospital deductible for inpatient and outpatient hospital services combined, then Nothing for inpatient hospital maternity charges	In-Network: $1,500 copayment for inpatient hospital maternity services, then Nothing for inpatient hospital charges Out-of-Network: 40% of charges after out-of-network deductible

Maternity care - continued on next page

Benefit Description	You Pay	
Maternity care (cont.)	**High Option**	**Standard Option**
• We cover routine nursery care of the newborn child and other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • We pay non-routine prenatal and postnatal care the same as for illness and injury. Note: When a newborn requires non-routine treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	$500 hospital deductible for inpatient and outpatient hospital services combined, then Nothing for inpatient hospital maternity charges	In-Network: $1,500 copayment for inpatient hospital maternity services, then Nothing for inpatient hospital charges Out-of-Network: 40% of charges after out-of-network deductible
• Breastfeeding and lactation support, supplies and counseling for each birth	Nothing	In-Network: Nothing Out-of-Network: 40% of charges after out-of-network deductible
Family planning	**High Option**	**Standard Option**
Contraceptive counseling	Nothing	In-Network: Nothing Out-of-Network: 40% of the charges after out-of-network deductible
We cover a range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms Note: See additional Family Planning and Prescription drug coverage Section 5(f) or 5(f)(a), if applicable. Note: Your plan offers voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	Nothing	In-Network: Nothing Out-of-Network: 40% of charges after out-of-network deductible

Family planning - continued on next page

Benefit Description	You Pay	
Family planning (cont.)	**High Option**	**Standard Option**
Voluntary male sterilization	$45 per office visit $500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*	*All charges*
Advance care planning	**High Option**	**Standard Option**
We cover advance care planning in an office	Nothing	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Medication therapy disease management program	**High Option**	**Standard Option**
If you meet our criteria for coverage, you may qualify for our Medication Therapy Disease Management Program. The program covers consultations with a designated pharmacist.	Nothing	In-Network: Nothing Out-of-Network: All charges
Infertility diagnosis and fertility services	**High Option**	**Standard Option**
We cover diagnosis of infertility	In- or Out-of-Network: 20% of charges	In- or Out-of-Network: 20% of charges after in-network deductible
We cover fertility treatment including: • Artificial insemination (AI) - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) Coverage is available with or without a diagnosis of infertility.	20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
We cover fertility drugs • Limited to products listed on the Formulary • Fertility drugs used with IVF are limited to three cycles per calendar year	40% of charges	In-Network: 40% of charges after in-network deductible Out-of-Network: All charges
We cover therapeutic preservation fertility services: These preservation services are for members that may become infertile due to chemotherapy, pelvic radiotherapy, other gonadotoxic therapies, or ovary or testicle removal for treatment of disease. This includes fertility services associated with gender affirming care. • Cryopreservation of sperm, oocyte, and embryo • Sperm, oocyte and embryo storage for up to one year • Thawing of preserved sperm, oocyte, and embryo	20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: All charges

Infertility diagnosis and fertility services - continued on next page

Benefit Description	You Pay	
Infertility diagnosis and fertility services (cont.)	**High Option**	**Standard Option**
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization (IVF)* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm or egg* • *Cost of storage of donor sperm, ova or embryo, except for therapeutic preservation services* • *Fertility treatment after reversal of sterilization* • *Artificial insemination for surrogate pregnancy*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
We cover: • Testing and treatment • Allergy injections and serum	$45 per office visit	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
We cover: • Chemotherapy • Intravenous (IV)/Infusion therapy	For services received in an office or outpatient hospital: 15% of charges Inpatient hospital services: $500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
• Radiation therapy • Dialysis – hemodialysis and peritoneal dialysis • Respiratory and inhalation therapy Note: Cardiac rehabilitation following a qualifying event/ condition is covered under Physical and occupational therapies on page 40.	For services received in an office or outpatient hospital: $45 per visit Inpatient hospital services: $500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
We cover Applied Behavior Therapy (ABA) and Intensive Early Intervention Behavioral Therapy (IEIBT) for the treatment of Autism Spectrum Disorder.	$45 per visit	In-Network: 20% of charges after in-network deductible Out-of-Network: All charges

Treatment therapies - continued on next page

Benefit Description	You Pay	
Treatment therapies (cont.)	**High Option**	**Standard Option**
• Specialty drugs We cover specialty drugs that are used to treat chronic health conditions including but not limited to such conditions as transplant recipients, immunological conditions, growth hormone, bleeding disorder, HIV/ AIDS. We require prior authorization for certain drugs and the site where the drug will be administered.	40% of charges	In-Network: 40% of charges, after deductible Out-of-Network: All charges
Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. See Services requiring our prior approval in Section 3. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other services under You need prior Plan approval for certain services on page 20.	20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Not covered: Growth hormones which are not for growth hormone deficiency or chronic renal insufficiency	*All charges*	*All charges*
We cover gene therapy treatment that meets our current medical coverage criteria. Gene therapy must be provided by a designated provider. Specific types of gene therapy are limited to therapies and conditions specified in our medical coverage criteria.	For services received in an office: $45 per visit For services received in a hospital: $500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges For services received in the home: 20% of the charges incurred	In-Network: 20% of charges after in-network deductible Out-of-Network: All charges
Physical and occupational therapies	**High Option**	**Standard Option**
We cover: • Rehabilitative therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. You must achieve significant functional improvement, within a predictable period of time (generally within a period of two months), toward your maximum potential ability to perform functional daily living activities. • Habilitative care rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and motor development.	For services received in an office or outpatient hospital: $45 per visit Inpatient hospital services: $500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible

Physical and occupational therapies - continued on next page

Benefit Description	You Pay	
Physical and occupational therapies (cont.)	**High Option**	**Standard Option**
Note: To be considered habilitative, significant functional improvement and measurable progress must be made toward achieving functional goals and your maximum potential ability, within a predictable period of time. Our Plan Medical Director will determine whether measurable progress has been made based on objective documentation.	For services received in an office or outpatient hospital: $45 per visit Inpatient hospital services: $500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
• Cardiac rehabilitation following a qualifying event/ condition is provided for Phase I and Phase II if it is medically necessary. Phase III and IV are not covered.	$45 per office visit Nothing for inpatient or outpatient hospital	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Not covered: • *Long-term rehabilitative therapy (maintenance care)* • *Health club memberships, exercise programs and use or purchase of exercise equipment*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
We cover: • Speech therapy for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech development. • Usually 60 visits or two months per condition per year	For services received in an office or outpatient hospital: $45 per visit Inpatient hospital services: $500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Not covered: Long term rehabilitative therapy (maintenance care)	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
We cover: • Treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) Preventive care, children.	Nothing	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
• External hearing aids for members age 18 or younger who have hearing loss that is not correctable by other covered procedures. Coverage is limited to one basic, standard hearing aid for each ear every three years. A basic hearing aid is defined as a hearing device that consists of a microphone, amplifier, volume control, battery and receiver. It does not include upgrades above and beyond the functionality of a basic hearing aid, including but not limited to hearing improvements for group settings, background noise, Bluetooth/remote control functionality, or extended warranties.	20% of the charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You Pay	
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
• Implanted hearing related devices, such as bone-anchored hearing aids (BAHA) and cochlear implants based on our criteria.	20% of the charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Not covered: • *Charges for upgrades above the cost of a basic, standard hearing aid* • *Hearing aids, testing and examinations for them, unless noted above*	*All charges*	*All charges*
• Hearing Aids The plan covers up to two TruHearing-branded hearing aids every year (one per ear per year). This benefit is limited to TruHearing Advanced and Premium hearing aids, which come in various styles and colors. Premium hearing aids are available in rechargeable style options for an additional $75 per aid. You must see a TruHearing provider to use this benefit. TruHearing offers a national network of providers. Call 833-718-5803 to schedule an appointment (for TTY, dial 711). Hearing aid purchase includes: • 3 provider visits within the first year of hearing aid purchase • 45-day trial period • 3-year extended warranty • 48 batteries per aid for non-rechargeable models This benefit does not include or cover any of the following: • Additional cost for optional hearing aid rechargeability • Ear molds • Hearing aid accessories • Additional provider visits • Additional batteries or batteries when a rechargeable hearing aid is purchased • Hearing aids that are not TruHearing-branded hearing aids • Costs associated with loss and damage warranty claims Costs associated with excluded items are the responsibility of the enrollee and not covered by the plan.	$699 copayment per aid for Advanced Aids* $999 copayment per aid for Premium Aids* A rechargeable battery option is available on some Premium hearing aids for an additional $75 per aid. **Please note that this service does not apply to your maximum out-of-pocket amount for medical services.*	*All charges*

Benefit Description	You Pay	
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
We cover: • Eye exams to determine the need for vision correction • Annual eye refractions Note: See *Preventive care, adult; Preventive care, children*	Nothing	In-Network: Nothing Out-of-Network: 40% of charges after out-of-network deductible
• Diagnosis and treatment of illness and injury to the eye	$45 per office visit	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Initial evaluation, lenses and fitting for contact or eyeglass lenses if medically necessary for the post surgical treatment of cataracts or for the treatment of aphakia, acute or chronic corneal pathology, or keratoconus	$45 per office visit All charges for lens replacement beyond the initial pair	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible *All charges for lens replacement beyond the initial pair*
Not covered: • Eyeglasses or contact lenses and their fitting, measurement and adjustment, except as shown above • Eyewear options, including, but not limited to, ultraviolet absorbing properties, scratch resistant protective coating, sunglasses in addition to other lenses, anti-reflective coating, edge treatment, fashion tints or polarized lenses, frames, contact lens cleaning solution or normal saline for contact lenses, progressive lenses or invisible bifocals, low vision aids or oversize lenses • Eye exercises and orthoptics • Vision correction (refractive) surgeries in otherwise healthy eyes to replace eyeglasses or contact lenses. Examples include, but are not limited to, LASIK, radial keratotomy, laser and other refractive eye surgery	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
We cover routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	$45 per office visit	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*

Benefit Description	You Pay	
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
We cover: • Artificial limbs • Artificial eye (ocular prosthesis), including polishing and adjustments • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Orthopedic and corrective shoes when approved by this Plan based on our criteria • Replacement or repair of DME or orthotics is covered to accommodate growth requirements or if needed due to a change in a medical condition which affects the fit or function of the item • Hearing aids and implantable hearing-related devices as described under Hearing Services on page 41. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility and ambulance services. *Coverage is limited to one prosthetic item unless bilateral prostheses are recommended and are Medically Necessary for both sides*	20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
• Wigs required due to hair loss caused by alopecia areata	20% of charges, and all charges beyond one wig per calendar year limit	In-Network: 20% of charges after in-network deductible, and all charges beyond one wig per calendar year limit Out-of-Network: 40% of charges after out-of-network deductible, and all charges beyond one wig per calendar year limit
Not covered: • *Over-the-counter foot orthotics* • *Non-custom orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Replacement or repair of any covered items if they are damaged or destroyed by member misuse, abuse or carelessness; lost; or stolen* • *Duplicate or similar items, including replacement or repair of duplicate or similar items*	*All charges*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• *Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience, recreation or safety* • *Other equipment and supplies, including but not limited to assistive devices, that we determine are not eligible for coverage*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment, when prescribed by your Plan physician. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Blood glucose monitors • Insulin pumps • Diabetic supplies • Disposable needles and syringes needed for the administration of covered medications • Compression garments Note: Covered items may be subject to limitations or require prior authorization. We reserve the right to determine if an item will be approved for rental vs. purchase.	20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Specialty dietary treatment for phenylketonuria (PKU) *No more than a 90-day supply of special dietary treatment for phenylketonuria is covered and dispensed at a time.*	20% of charges	In-Network: 20% of charges Out-of-Network: 40% of charges after out-of-network deductible
Not covered: • *Replacement or repair of any covered items if they are damaged or destroyed by member misuse, abuse or carelessness; lost; or stolen* • *Duplicate or similar items* • *Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience or recreation* • *Household equipment, such as exercise cycles, air purifiers, water purifiers, air conditioners, non-allergenic pillows, mattresses or water beds* • *Household fixtures, such as escalators or elevators, ramps, swimming pools or saunas* • *Modifications to the home, such as wiring, plumbing or charges to install equipment*	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
• *Vehicle, car or van modifications, such as hand brakes, hydraulic lifts and car carriers* • *Rental of medically necessary durable medical equipment while your own equipment is being repaired, that is beyond one month rental* • *Other equipment and supplies, including but not limited to assistive devices, that we determine are not eligible for coverage* • *We require that certain diabetic supplies and equipment be purchased at a pharmacy*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
We cover home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or home health aide, as shown below. You need to be homebound (i.e., unable to leave home without considerable effort due to a medical condition) to receive home health services. You do not need to be homebound to receive total parenteral nutrition/intravenous ("TPN/IV") therapy. • At home physical therapy, occupational therapy, speech therapy, respiratory therapy and home health aide services	$45 per visit	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
• TPN/intravenous therapy (other than specialty drugs described below), skilled nursing services, nonroutine prenatal and postnatal services, and phototherapy	20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
• Specialty drugs administered in home We cover specialty drugs that are used to treat chronic health conditions including but not limited to such conditions as transplant recipients, immunological conditions, growth hormone, bleeding disorder, HIV/AIDS. We require prior authorization for certain drugs and the site where the drug will be administered.	40% of charges	In-Network: 40% of charges, after deductible Out-of-Network: All charges
• Palliative care Palliative care includes symptom management, education and establishing goals of care. If you are eligible to receive palliative care in the home and you are not homebound, there is a maximum of 12 visits per calendar year. 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. Note: We waive the requirement that you be homebound if you have a serious illness or life-limiting condition.	$45 per visit	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible

Home health services - continued on next page

Benefit Description	You Pay	
Home health services (cont.)	**High Option**	**Standard Option**
• Routine prenatal and postnatal services and child health services	Nothing	In-Network: Nothing Out-of-Network: 40% of charges after out-of-network deductible
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
We cover chiropractic services for rehabilitative care, provided to diagnose and treat neuromusculoskeletal conditions, limited to: • Manipulation of the spine • Adjunctive procedures such as massage therapy, ultrasound, electrical muscle stimulation, and vibratory therapy, when they are performed in conjunction with other treatment by a chiropractor, are part of a prescribed treatment plan and are not billed separately	$45 per office visit	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Not covered: • *Massage therapy as a standalone treatment* • *Naturopathic services* • *Hypnotherapy*	*All charges*	*All charges*
Alternative treatments	**High Option**	**Standard Option**
We cover: • Acupuncture • Biofeedback for: - incontinence - headaches - musculo-skeletal spasms which do not respond to other treatments - mental/nervous disorders	$45 per office visit	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Not covered: • *Naturopathic services* • *Hypnotherapy*	*All charges*	*All charges*

Benefit Description	You Pay	
Educational classes and programs	**High Option**	**Standard Option**
We cover: • Education for preventive services • Tobacco cessation programs, including individual, group, phone counseling, and physician prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat nicotine dependence. Includes up to two quit attempts and up to four counseling sessions • Physician prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence whether or not one is enrolled in a smoking cessation program • Education for the management of chronic health problems (such as diabetes)	Nothing	In-Network: Nothing Out-of-Network: 40% of charges after out-of-network deductible

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- For you to receive in-network benefits, Plan physicians must provide your care.
- Be sure to read Section 4, *Your Cost for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. The amount that you pay for these services depends on where the services are provided and follows the benefits described in Section 5(a) and 5(c) unless otherwise specified below.
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR SOME SURGICAL PROCEDURES.** Please refer to the prior authorization information shown in Section 3 to be sure which services require prior authorization.
- For you to receive in-network benefits, Plan physicians must provide your care.
- For High Option. The plan includes a $500 calendar year deductible specific only to inpatient and outpatient hospital services and MRI/CT scans.
- For Standard Option. For Network Expenses: The calendar year deductible is $750 for persons enrolled for Self Only coverage, $1,500 for persons enrolled for Self Plus One coverage and $1,500 for families enrolled for Self and Family coverage. For Out-of-Network Expenses: The calendar year deductible is $2,000 for persons enrolled for Self Only coverage, $4,000 for persons enrolled for Self Plus One coverage and $4,000 for families enrolled for Self and Family coverage. The calendar year deductible applies to almost all Standard Option benefits in this Section. We added "deductible does not apply" to show when the calendar year deductible does not apply.

Benefit Description	You Pay	
For Standard Option, a calendar year deductible applies to all benefits in this Section.		
Surgical procedures	**High Option**	**Standard Option**
We cover a comprehensive range of services, such as: • Operative procedures, including normal pre- and post-operative care by the surgeon • Treatment of fractures, including casting • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Treatment of burns • Gender confirmation surgery that meets medical coverage criteria • Insertion of internal prosthetic devices. See 5(a) -- *Orthopedic and prosthetic devices* for device coverage information Note: For female surgical family planning procedures see Family Planning Section 5(a)	$45 per office visit $500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible

Surgical procedures - continued on next page

Benefit Description	You Pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
Note: For male surgical family planning procedures see Family Planning Section 5(a) Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$45 per office visit $500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Surgical treatment of severe obesity (bariatric surgery) See *Services requiring our prior approval* on page 19. See bariatric surgery criteria available at www.healthpartners.com/public/coverage-criteria/	$45 per office visit $500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges.	In-Network: 20% of charges after in-network deductible Out-of-Network: All charges
Not covered: • *Reversal of voluntary sterilization*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
We cover: • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance; and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities, cleft lip, cleft palate, birth marks, port wine stains, webbed fingers and webbed toes. Note: Port wine stains do not have to result in a functional defect to be covered. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas - breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$45 per office visit $500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible

Reconstructive surgery - continued on next page

Benefit Description	You Pay	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
• Gender affirming (confirmation) surgery that meets medical coverage criteria, including breast augmentation, mastectomy, reduction mammoplasty, orchidectomy, penectomy, urethroplasty, vaginoplasty, labiaplasty, clitoroplasty, hysterectomy, salpingectomy, oophorectomy, vaginectomy and phalloplasty or metoidioplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis. Prior authorization is required.	$45 per office visit $500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Not covered: • *Surgery, services, treatments or drugs that improve or enhance the shape or appearance of the body for purposes other than treating an illness or injury. These types of services are considered cosmetic and are not covered whether or not they also impact your psychological/emotional well-being or self-esteem. Examples include but are not limited to enhancement procedures, reduction procedures and scar revision surgery. This exclusion does not apply to services for port wine stain removal, reconstructive surgery, gender confirmation services and emergency care required due to complications of Cosmetic Surgery.*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
We cover oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures, including non-dental treatment of temporomandibular joint dysfunction (TMJ)	$45 per office visit $500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
We cover orthognathic surgery for the treatment of a skeletal malocclusion when a functional occlusion cannot be achieved through non-surgical treatment alone and a demonstrable functional impairment exists.	25% of charges	In-Network: 25% of charges after in-network deductible Out-of-Network: 50% of charges after out-of-network deductible
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)* • *Orthodontic services (pre or post operative) associated with orthognathic surgery*	*All charges*	*All charges*

Benefit Description	You Pay	
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental investigational review by the Plan. See Other services in Section 3 for prior authorization procedures. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants: - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas	$500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
These **tandem blood or marrow stem cell transplants for covered transplants** are not subject to medical necessity review by the Plan. Refer to *Other Services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	$500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
These **blood or marrow stem cell transplants** are not subject to medical necessity and experimental investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases will respond to treatment without transplant and which diseases may respond to transplant. The Plan extends coverage for the diagnosis as indicated below.	$500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Acute myeloid leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced Myeloproliferative Disorders (MPDs) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Hurler's syndrome, Maroteaux-Lamy syndrome • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, pure red cell aplasia) • Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Myelodysplasia/myelodysplastic syndromes • Paroxysmal nocturnal hemoglobinuria • Phagocytic/hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Sickle cell anemia • X-linked lymphoproliferative syndrome **Autologous** transplants for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • AL Amyloidosis • Breast Cancer • Epithelial ovarian cancer • Multiple myeloma • Neuroblastoma • Recurrent germ cell tumors (including testicular, mediastinal, retroperitoneal)	$500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: **Allogeneic** transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Acute myeloid leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced Myeloproliferative Disorders (MPDs) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Chronic myelogenous leukemia • Hemoglobinopathy • Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia **Autologous** transplants for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Neuroblastoma	$500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.	$500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Allogeneic transplants for • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Sickle cell anemia **Autologous** transplants for • Advanced childhood kidney cancers • Advanced Ewing sarcoma • Childhood rhabdomyosarcoma • Mantle cell (Non-Hodgkin lymphoma)	$500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
HealthPartners Designated Transplant Providers and HealthPartners Centers of Excellence - These are local and national Designated Transplant Centers based upon their experience, clinical outcomes, service, access, cost, coordination of care, research and education. For a list of participating programs visit www.healthpartners.com/pshb.	Transplant procedures must be performed at HealthPartners Designated Transplant Centers	In-Network: transplant procedures must be performed at HealthPartners Designated Transplant Centers to receive in-network benefits
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor screening tests and donor search expense for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	$500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*

Benefit Description	You Pay	
Anesthesia	**High Option**	**Standard Option**
We cover professional services provided in – • Hospital (inpatient) • Skilled nursing facility • Hospital outpatient department • Ambulatory surgical center	$500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
We cover professional services provided in an office	$45 per office visit	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Travel Benefit	**High Option**	**Standard Option**
We may provide travel and lodging when an enrollee needs a transplant or CAR-T therapy and a designated transplant center or CAR-T treatment center is greater than 100 miles from the enrollee's primary address. To receive reimbursement for eligible travel and lodging expenses, the Insured will need to submit a Travel Benefit Claim Form, including receipts of services. Log on to your account at www.healthpartners.com/pshb or call Member Services to access the Travel Benefit Claim Form or to determine if additional Coverage Criteria Policies apply.	20% of charges Expenses for travel, and lodging for the enrollee (the recipient) and one adult companion, or up to two companions for a recipient that is a minor dependent, may be covered, up to a maximum of $10,000 per transplant or CAR-T therapy. Lodging coverage is limited to $100 per day.	20% of charges Expenses for travel, and lodging for the enrollee (the recipient) and one adult companion may be covered, up to a maximum of $10,000 per transplant or CAR-T therapy. Commercial lodging reimbursement (as may be adjusted by IRS rules) is limited to a maximum of $50 per night if the Insured travels alone or a maximum of $100 per night if the Insured travels with a companion. Out-of-Network: All Charges

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- For you to receive in-network benefits, Plan physicians must provide your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your Cost for Covered Services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR SOME HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require prior authorization.
- For High Option. The plan includes a $500 calendar year deductible specific only to inpatient and outpatient hospital services and MRI/CT scans.
- For Standard Option. For Network Expenses: The calendar year deductible is $750 for persons enrolled for Self Only coverage, $1,500 for persons enrolled for Self Plus One coverage and $1,500 for families enrolled for Self and Family coverage. For Out-of-Network Expenses: The calendar year deductible is $2,000 for persons enrolled for Self Only coverage, $4,000 for persons enrolled for Self Plus One coverage and $4,000 for families enrolled for Self and Family coverage. The calendar year deductible applies to almost all Standard Option benefits in this Section. We added "deductible does not apply" to show when the calendar year deductible does not apply.

Benefit Description	You Pay	
For Standard Option, a calendar year deductible applies to all benefits in this Section.		
Inpatient hospital	**High Option**	**Standard Option**
We cover room and board, such as • Ward, semiprivate or intensive care accommodations • General nursing care • Meals and special diets For Maternity Care see page 36. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
We cover other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma (unless replaced) and blood derivatives • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services	$500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• Take-home items • Medical supplies, appliances, medical equipment and any covered items billed by a hospital for use at home • MRI / CT scans	$500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as phone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
We cover: • Operating, recovery and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays and pathology services • Administration of blood, blood plasma and other biologicals • Pre-surgical testing • Dressings, casts and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • MRI / CT scans Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
• Blood and blood plasma (unless replaced) and blood derivatives	15% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
• Specialty drugs We cover specialty drugs that are used to treat chronic health conditions including but not limited to such conditions as transplant recipients, immunological conditions, growth hormone, bleeding disorder, HIV/AIDS. We require prior authorization for certain drugs and the site where the drug will be administered.	40% of charges	In-Network: 40% of charges, after in-network deductible Out-of-Network: All charges

Benefit Description	You Pay	
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
We cover a comprehensive range of benefits for up to 120 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by your Plan doctor and prior authorized by this Plan. All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, services and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by your Plan doctor.	$500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Not covered: Custodial care	*All charges*	*All charges*
Home hospice care	**High Option**	**Standard Option**
We cover supportive and palliative care in your home or a hospice if you are terminally ill. We cover the following services: • Outpatient care, family counseling and continuous care • Inpatient care, when medically necessary • Respite care • End of life care Note: Respite care is limited to 5 days per episode, and respite care and continuous care combined are limited to 30 days. Note: *Inpatient hospital care*: designed for those patients who require an acute hospital admission for pain or symptom control related to the terminal illness. *Free-standing hospice*: a hospice inpatient unit set up as a geographically distinct building. *Residential hospices/ hospice houses*: goal is to provide longer-term care, in homelike settings, for patients who cannot be cared for in their own homes. Staffing and intensity of services are comparable to a board-and-care home or other types of licensed residential facility. A residential hospice program may be operated by a home care hospice or by an independent agency that contracts with a community hospice for professional services. Payment for residential room and board is made privately.	Nothing	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Not covered: • *Independent nursing, homemaker services* • *Room and board expenses in a residential hospice facility, free standing hospice or skilled nursing facility*	*All charges*	*All charges*

Benefit Description	You Pay	
Ambulance	**High Option**	**Standard Option**
Ambulance and medical transportation for medical emergencies described in Section 5(d) and non-emergency medical transportation when medically appropriate. The amount you pay for air ambulance services will be determined based on the requirements of the No Surprises Act and its implementing regulations.	In- or Out-of-Network: 20% of charges	In- or Out-of-Network: 20% of charges after in-network deductible
Note: *Fixed Wing Air Ambulance* transport requires prior authorization from HealthPartners. *Fixed Wing Air Ambulance* is an aircraft such as an airplane, jet, or turbo prop plan that is able to travel longer distances than its counterpart, the Rotary Wing Air Ambulance (i.e. the helicopter). Under the No Surprises Act, Non-Network air ambulance providers may not bill patients for more than their cost-sharing responsibility for the corresponding Network service.		

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your Cost for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- For High Option. The plan includes a $500 calendar year deductible specific only to inpatient and outpatient hospital services and MRI/CT scans.
- For Standard Option. For Network Expenses: The calendar year deductible is $750 for persons enrolled for Self Only coverage, $1,500 for persons enrolled for Self Plus One coverage and $1,500 for families enrolled for Self and Family coverage. For Out-of-Network Expenses: The calendar year deductible is $2,000 for persons enrolled for Self Only coverage, $4,000 for persons enrolled for Self Plus One coverage and $4,000 for families enrolled for Self and Family coverage. The calendar year deductible applies to almost all Standard Option benefits in this Section. We added "deductible does not apply" to show when the calendar year deductible does not apply.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

In life-threatening emergencies, contact the local emergency system (e.g., 911 phone system) or go to the nearest hospital emergency room. In other situations, if you need emergency care, call your clinic, or, after clinic hours, call the CareLine® service at 612-339-3663 or 800-551-0859 (TTY: 711). A CareLine nurse or Plan doctor will recommend how, when and where to obtain the appropriate treatment.

Emergencies Out-of-Network:

You should notify us within two days of admittance to an out-of-network hospital, or as soon as reasonably possible under the circumstances. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible. Follow-up care recommended by non-Plan providers must be approved by this Plan or provided by our providers.

Under the No Surprises Act, out-of-network emergency care providers may not bill patients for more than their cost sharing responsibility for the corresponding in-network service.

Benefit Description	You Pay	
For Standard Option, a calendar year deductible applies to almost all benefits in this Section. We specify when it does not apply.		
Emergency care	**High Option**	**Standard Option**
We cover: • Emergency and urgently needed services at a doctor's office • Emergency and urgently needed services at an urgent care clinic If other services are performed during the visit, such as diagnostic imaging or laboratory services, additional Deductible, Copayment or Coinsurance may apply. Diagnostic imaging services and laboratory services are covered under the "Lab, X-ray and other diagnostic tests" section.	$45 per office visit	$0 for the first 5 office, convenience clinic, telephone, urgent care visits, evisits and video visits combined in a calendar year (deductible does not apply), then 20% of charges, subject to the in-network deductible. Physician's services, laboratory and radiology performed in conjunction with the same visit and on the same date of service are included; however, charges for day treatment services, group visits, office procedures and other ancillary services are not included and will be subject to your deductible and coinsurance.
• Emergency and urgently needed services as an outpatient in a hospital, including doctors' services The amount you pay for these services will be determined based on the requirements of the No Surprises Act and its implementing regulations.	$250 per visit The ER copayment is waived if you are admitted to the hospital	20% of charges after in-network deductible
• Emergency and urgently needed inpatient hospital services The amount you pay for these services will be determined based on the requirements of the No Surprises Act and its implementing regulations.	$500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of charges	20% of charges after in-network deductible

Benefit Description	You Pay	
Ambulance	**High Option**	**Standard Option**
Ambulance and medical transportation for medical emergencies described in this section and non-emergency medical transportation when medically appropriate. The amount you pay for air ambulance services will be determined based on the requirements of the No Surprises Act and its implementing regulations. Under the No Surprises Act, out-of-network air ambulance providers may not bill patients for more than their cost-sharing responsibility for the corresponding in-network service.	In- or Out-of-Network: 20% of charges	In- or Out-of-Network: 20% of charges after in-network deductible
Note: Fixed Wing Air Ambulance transport requires prior authorization from HealthPartners. *Fixed Wing Air Ambulance* is an aircraft such as an airplane, jet, or turbo prop plan that is able to travel longer distances than its counterpart, the Rotary Wing Air Ambulance (i.e. the helicopter). Under the No Surprises Act, Non-Network air ambulance providers may not bill patients for more than their cost-sharing responsibility for the corresponding Network service.		

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **You do not need a referral** from your primary care provider to obtain mental health or substance abuse services.
- Our Behavioral Health Personalized Assistance Line (PAL) staff can match you with a network provider who can meet your behavioral health needs. We can identify providers by specialty and by specific diagnostic, language and cultural competence. If you have an urgent need, we can link you to same day/next day psychiatric appointments. Call 952-883-5811 or 888-638-8787.
- For High Option. The plan includes a $500 calendar year deductible specific only to inpatient and outpatient hospital services and MRI/CT scans.
- For Standard Option. For Network Expenses: The calendar year deductible is $750 for persons enrolled for Self Only coverage, $1,500 for persons enrolled for Self Plus One coverage and $1,500 for families enrolled for Self and Family coverage. For Out-of-Network Expenses: The calendar year deductible is $2,000 for persons enrolled for Self Only coverage, $4,000 for persons enrolled for Self Plus One coverage and $4,000 for families enrolled for Self and Family coverage. The calendar year deductible applies to almost all Standard Option benefits in this Section. We added "deductible does not apply" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Cost for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
For Standard Option, a calendar year deductible applies to almost all benefits in this Section. We specify when it does not apply.		
Professional services	**High Option**	**Standard Option**
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost sharing responsibilities are no greater than for other illnesses or conditions	Your cost sharing responsibilities are no greater than for other illnesses or conditions
We cover diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy • Gender affirming care for gender dysphoria	$45 per visit	In-Network: $0 for the first 5 office, convenience clinic, telephone, urgent care visits, evisits and video visits combined in a calendar year (deductible does not apply), then 20% of charges, subject to the in-network deductible. Physician's services, laboratory and radiology performed in conjunction with the same visit and on the same date of service are included; however, charges for day treatment services, group visits, office procedures and other ancillary services are not included and will be subject to your deductible and coinsurance. Out-of-Network: 40% of charges after out-of-network deductible

Professional services - continued on next page

Benefit Description	You Pay	
Professional services (cont.)	**High Option**	**Standard Option**
Group therapy visits for mental health	$22.50 per visit	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Diagnostics	**High Option**	**Standard Option**
We cover: • Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	$45 per visit	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
We cover inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, residential treatment, and other hospital services	$500 hospital deductible for inpatient and outpatient hospital services combined, then 20% of inpatient hospital charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
We cover outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, full-day hospitalization, or facility-based intensive outpatient treatment	$45 per visit	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Not covered	**High Option**	**Standard Option**
• Marriage or relationship counseling services • Sex therapy • Religious counseling • Wilderness and outdoor programs even when the program is through a licensed facility • Animal therapy, including hippotherapy and equine therapy • Professional services associated with substance use disorder interventions. A “substance use disorder intervention” is a gathering of family and/or friends to encourage an Enrollee or family member to seek substance use disorder treatment.	*All charges*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorization must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- Be sure to read Section 4, *Your Cost for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- For Standard Option. For Network Expenses: The calendar year deductible is $750 for persons enrolled for Self Only coverage, $1,500 for persons enrolled for Self Plus One coverage and $1,500 for families enrolled for Self and Family coverage. For Out-of-Network Expenses: The calendar year deductible is $2,000 for persons enrolled for Self Only coverage, $4,000 for persons enrolled for Self Plus One coverage and $4,000 for families enrolled for Self and Family coverage. The deductible does not apply to generic formulary drugs. The deductible does apply to brand and specialty drugs. We added "deductible does not apply" to show when the calendar year deductible does not apply.
- The Plan uses the *PreferredRx Formulary*. It excludes drugs for sexual dysfunction. Other drugs may be excluded for certain indications.
- See section 9 for the EGWP opt out process.

There are important features you should be aware of. These include:

- **Biosimilar drugs**, regardless of interchangeability status, are not considered Generic Drugs and are not covered under the Generic Drug benefit. A biosimilar drug is a Prescription Drug that the FDA has determined is highly-similar to a biological Brand Name Drug. HealthPartners will review each biosimilar drug and establish formulary, coverage and specialty designations.
- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.**
  - **High Option:** You must fill the prescription at a Plan pharmacy or by mail.
  - **Standard Options:** For in-network benefits, you must fill the prescription at a Plan pharmacy or by mail. Out-of-network benefits apply when you do not use a Plan pharmacy.
  - **For both Options, specialty drugs** must be obtained at a designated vendor. The specialty drug list is available by calling Member Services or by visiting our website at www.healthpartners.com/pshb.
- The plan uses the **PreferredRx formulary**. Check to see which drugs are covered and the level of coverage. The formulary excludes drugs for sexual dysfunction.
- **We cover formulary drugs**. Formulary drugs are a list of drugs that we selected to meet patient needs at a lower cost. For information on the formulary exception process visit www.healthpartners.com/pshb.
- **These are the dispensing limitations.** Unless otherwise specified in this section, you may receive up to a 30-day supply per prescription. Certain drugs may require prior authorization or have quantity limits. HealthPartners may require prior authorization for the drug and also the site where the drug will be provided. The Formulary and information on drugs with limitations are available by calling Member Services or logging on to your HealthPartners account at www.healthpartners.com/pshb. All drugs are subject to our utilization review process and quantity limits. New prescriptions to treat certain chronic conditions are limited to a 30-day supply. Certain drugs may be subject to our trial drug program. A 90-day supply will be covered and dispensed only at pharmacies that participate in our extended day supply program. No more than a 30-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 enrollee with more than a 30-day supply, or unless specified on the specialty drug list. If a copayment is required, you must pay one copayment for each 30-day supply, or portion thereof, except for mail order drugs, see benefit described below.

- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand through a prior authorization submission, and that request is approved. Other formulary limitations, such as quantity limits, may still apply. If your physician does not require a brand name drug or we do not approve the request, you have to pay your applicable copayment or coinsurance plus the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you – and us - less than a name brand prescription.
- **If you request a refill too soon** after the last one was filled, it may not be filled at that time. It may require up to 14 days to get mail order prescriptions filled, so this service is best for maintenance drugs, not for drugs you need immediately or for drugs you are taking on a short-term basis. Federal or state regulations may prevent us from filling certain prescriptions through mail order service, such as laws that prohibit us from sending narcotic drugs across state lines.
- **Cost Sharing Limits for Insulin:** We will limit your cost-sharing on prescription insulin to no more than the net price of the prescription insulin drug. This applies at the point of sale, including deductible payments and the cost-sharing amounts charged once the deductible is met. Cost-sharing means a deductible payment, copayment, or coinsurance amount that you must pay for covered prescription insulin in accordance with the terms and conditions of this health plan. Net price is our cost for prescription insulin, including any rebates or discounts received by or accrued directly or indirectly to us from a drug manufacturer or pharmacy benefit manager.
- **When you have to file a claim.** You do not need to file a claim for drugs obtained at a network pharmacy or through our designated mail order service. You would need to file a claim for prescription drugs covered as part of an out-of-area emergency, if you did not get them at a network pharmacy. See Section 7 for instructions on filing a claim.

A member who is called to active military duty can call HealthPartners Member Services Department at 844-440-1900 to get information on how to get a medium-term, 3 month supply of drugs.

In the event of a national or other emergency, you can call HealthPartners Member Services Department at 844-440-1900 to get information on how to get a supply of drugs to meet your needs.

Benefit Description	You Pay	
For Standard Option, a calendar year deductible applies to almost all benefits in this Section. The deductible does not apply to generic formulary drugs.		
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following formulary medications and supplies prescribed by a licensed provider and obtained from a Plan pharmacy or through our designated mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered. • Insulin • Gender affirming drugs. Preferred outpatient products and any authorization requirements are noted in the Drug Formulary. • Medications prescribed to treat obesity Authorization requirements are noted in the Drug Formulary	$5 for low cost generic formulary drugs $25 for high cost generic formulary drugs $75 for preferred brand-name formulary drugs 40% coinsurance for non-preferred brand-name formulary drugs The copayment applies per 30-day supply, or portion thereof	In-Network: $5 for low cost generic formulary drugs (deductible does not apply) $25 for high cost generic formulary drugs (deductible does not apply) $75 for preferred brand-name formulary drugs after in-network deductible 40% coinsurance for non-preferred brand-name formulary drugs after in-network deductible The copayment applies per 30-day supply, or portion thereof Out-of-Network: 40% of charges after out-of-network deductible

Covered medications and supplies - continued on next page

Benefit Description	You Pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
We cover all FDA approved contraceptive methods as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines, including over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process. Your prescriber will obtain prior approval. Contact Member Services at 844-440-1900 (TTY: 711) for information on this process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Note: For additional Family Planning benefits see Section 5(a) Notes: • Coverage is limited to females (based on sex assigned at birth) • This benefit applies whether the birth control drug or device is used for birth control or for a medically necessary purpose other than birth control. • Over-the-counter contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider. These may be purchased at a pharmacy counter.	Nothing for formulary drugs Nothing if a Provider requests that a Non-Formulary contraceptive drug be dispensed as written	In-Network: Nothing for formulary drugs; Nothing if a Provider requests that a Non-Formulary contraceptive drug be dispensed as written Out-of-Network: 40% of charges after out-of-network deductible
Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco and nicotine dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)		
Opioid rescue agents, such as naloxone nasal sprays are covered under this Plan. Generic nasal spray (4 mg) is covered with no cost sharing when obtained from a network pharmacy. For more information consult the FDA guidance at: https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/		

Covered medications and supplies - continued on next page

Benefit Description	You Pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Preventive Medications with USPSTF A or B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing	In-Network: Nothing Out-of-Network: 40% of charges after out-of-network deductible
Diabetic supplies limited to • disposable needles and syringes for the administration of covered medications • blood glucose testing meters and strips • other diabetes supplies such as lancets and pen needles or insulin syringes	20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Drugs for breast cancer prevention for individuals at high risk for breast cancer who have not yet been diagnosed with the disease	Nothing for formulary drugs	In-Network: Nothing for formulary drugs Out-of-Network: 40% of charges after out-of-network deductible
We cover specialty drugs. Note: Specialty drugs are injectable and oral medications that are used to treat chronic health conditions including but not limited to such conditions as transplant recipients, immunological conditions, growth hormone, bleeding disorder, HIV/AIDS. We require prior authorization for certain drugs and the site where the drug will be administered. Please refer to the drug plan formulary to determine if the drug you have been prescribed by your physician needs to be filled by one of the plan's Specialty Pharmacy providers. • For safety, all mailing will be shipped based on temperature requirements and considerations. • Specialty drugs cannot be obtained through the traditional 90-day mail order program.	40% coinsurance for specialty drugs	In-Network: 40% coinsurance for specialty drugs, after in-network deductible Out-of-Network: *All charges*
We cover oral chemotherapy drugs. Note: oral chemotherapy drugs must be obtained from a designated vendor	40% coinsurance for formulary drugs	In-Network: 40% coinsurance for formulary drugs, after in-network deductible Out-of-Network: *All charges*

Covered medications and supplies - continued on next page

Benefit Description	You Pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Nonprescription (over-the counter) drugs, including, but not limited to vitamins, nutrients, medical foods, food supplements and homeopathic remedies, even if a physician prescribes or administers them, except as specified in this brochure or on the Formulary and prescribed by a physician or legally authorized health care provider under applicable state and federal law.* • *Non-Formulary Drugs, unless a Formulary exception has been granted through the Formulary exception process* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies (High Option only)* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Sexual dysfunction drugs* • *Replacement of prescription drugs, equipment and supplies due to loss, damage or theft* • *Medical cannabis* • *Drugs that are newly approved by the FDA until they are reviewed and coverage is established by HealthPartners Pharmacy and Therapeutics Committee.* • *Drugs on the Excluded Drug List. The Excluded Drug List includes select drugs within a therapy class that are not eligible for coverage. This includes drugs that may be excluded for certain indications. The Excluded Drug List is available at www.healthpartners.com/pshb*	*All charges*	*All charges*
Mail order benefits	**High Option**	**Standard Option**
You may also get outpatient formulary prescription drugs which can be self-administered through the designated mail order service. For information on how to obtain drugs through HealthPartners mail order service, please visit www.healthpartners.com/pshb. This benefit does not apply to drugs listed under Limited Benefits below.	$10 for low cost generic formulary drugs $50 for high cost generic formulary drugs $150 for preferred brand-name formulary drugs 40% coinsurance for non-preferred brand-name formulary drugs The copayment applies per 90-day supply, or portion thereof	In-Network: $10 for low cost generic formulary drugs (deductible does not apply) $50 for high cost generic formulary drugs (deductible does not apply) $150 for preferred brand-name formulary drugs after in-network deductible 40% coinsurance for non-preferred brand-name formulary drugs after in-network deductible The copayment applies per 90-day supply, or portion thereof Out-of-Network: all charges

Benefit Description	You Pay	
Prescription drug benefits - limited benefits	**High Option**	**Standard Option**
Growth hormones	20% of charges	In-Network: 20% of charges after in-network deductible Out-of-Network: 40% of charges after out-of-network deductible
Fertility drugs • Limited to products listed on the Formulary • Fertility drugs used with IVF are limited to three cycles per calendar year	40% of charges	In-Network: 40% of charges after in-network deductible Out-of-Network: All charges

Section 5(f)(a). PDP EGWP Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- These prescription drug benefits are for members enrolled in the HealthPartners Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).
- If you are a Postal Service annuitant and their covered Medicare-eligible family member, you will be automatically group enrolled in our PDP EGWP. Contact us for additional information at 844-440-1900.

Note: Notify us as soon as possible if you or your eligible family member is already enrolled in a Medicare Part D Plan. Enrollment in our PDP EGWP will cancel your enrollment in another Medicare Part D plan.

There are advantages to being enrolled in our PDP EGWP:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, you have a pharmacy network that may include pharmacies that are out-of-network or excluded for those enrolled in our standard non-PDP EGWP Prescription Drug Program.

We cover drugs, medications, and supplies as described below and on the following pages.

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorization must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- Be sure to read Section 4, *Your Cost for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- For Standard Option. The Medicare Part D calendar year deductible is $590 per person. The deductible does not apply to generic formulary drugs. The deductible does apply to brand and specialty drugs. We added "deductible does not apply" to show when the calendar year deductible does not apply.
- If you are enrolled in the HealthPartners PDP, when your Part D prescription drug copayments and/or coinsurance total $2,000 in a calendar year, you do not have to pay any more for covered Part D prescription drugs for the remainder of that calendar year.
- The PSHB Plan uses the *PreferredRx Formulary*. The HealthPartners PDP plan uses the *HealthPartners Medicare Formulary*. Both formularies exclude drugs for sexual dysfunction. Other drugs may be excluded for certain indications.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage.
- If you choose to opt out of or disenroll from our PDP EGWP, see Section 9 for additional PDP EGWP information and for our opt-out and disenrollment process. Contact us for assistance with the PDP EGWP opt out and disenrollment process at 844-440-1900.

Warning:If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage.

Note:If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll during Open Season or for a QLE. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance at 844-440-1900.

Each new enrollee will receive a description of our PDP EGWP Summary of Benefits and a dual coverage prescription drug identification card.

There are important features you should be aware of. These include:

- **Biosimilar drugs**, A biosimilar drug is a Prescription Drug that the FDA has determined is highly-similar to a biological Brand Name Drug. HealthPartners will review each biosimilar drug and establish formulary, coverage and specialty designations.
- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. Your prescribers must have Medicare-approved prescriptive authority.
- **Where you can obtain them**.
  - **High Option:** You must fill the prescription at a Plan pharmacy or by mail.
  - **Standard Options:** For in-network benefits, you must fill the prescription at a Plan pharmacy or by mail. Out-of-network benefits apply when you do not use a Plan pharmacy.

    For assistance locating a PDP EGWP network pharmacy, visit our website at www.healthpartners.com/pshb, or call us at 844-440-1900.
- **We have a managed formulary.** The PSHB Plan uses the **PreferredRx Formulary**. The HealthPartners PDP plan uses the **HealthPartners Medicare Formulary**. Your provider may prescribe drugs that are subject to additional review to determine they are medically necessary. You may view our formulary on our website at www.healthpartners.com/pshb, or call us at 844-440-1900. Check to see which drugs are covered and the level of coverage. The formulary excludes drugs for sexual dysfunction. For information on the formulary exception process visit www.healthpartners.com/pshb.
- **These are the dispensing limitations.** Unless otherwise specified in this section, you may receive up to a 30-day supply per prescription. Certain drugs may require prior authorization or have quantity limits. HealthPartners may require prior authorization for the drug and also the site where the drug will be provided. The Formulary and information on drugs with limitations are available by calling Member Services or logging on to your HealthPartners account at www.healthpartners.com/pshb. All drugs are subject to our utilization review process and quantity limits. New prescriptions to treat certain chronic conditions are limited to a 30-day supply. A 90-day supply will be covered and dispensed only at pharmacies that participate in our extended day supply program. No more than a 30-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 enrollee with more than a 30- day supply, or unless specified on the specialty drug list. If a copayment is required, you must pay one copayment for each 30-day supply, or portion thereof, except for mail order drugs, see benefit described below.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand through a prior authorization submission, and that request is approved. Other formulary limitations, such as quantity limits, may still apply.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you – and us - less than a name brand prescription.
- **If you request a refill too soon** after the last one was filled, it may not be filled at that time. It may require up to 14 days to get mail order prescriptions filled, so this service is best for maintenance drugs, not for drugs you need immediately or for drugs you are taking on a short-term basis. Federal or state regulations may prevent us from filling certain prescriptions through mail order service, such as laws that prohibit us from sending narcotic drugs across state lines.
- **When you have to file a claim.** You do not need to file a claim for drugs obtained at a network pharmacy or through our designated mail order service. You would need to file a claim for prescription drugs covered as part of an out-of-area emergency, if you did not get them at a network pharmacy. See Section 7 for instructions on filing a claim.
- **If we deny your claim and you want to appeal**, you, your representative, or your prescriber must request an appeal following the process described in Section 8(a) of this brochure and Chapter 7 of the Prescription Drug Plan Evidence of Coverage. The PDP EGWP appeals process has 5 levels. If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions in the decision letter on how to move to the next level of appeal.

PDP EGWP Catastrophic Maximum

If you are enrolled in the HealthPartners PDP, when your Part D prescription drug copayments and/or coinsurance total $2,000 in a calendar year, you do not have to pay any more for covered Part D prescription drugs for the remainder of that calendar year.

A member who is called to active military duty can call HealthPartners Member Services Department at 844-440-1900 to get information on how to get a medium-term, 3 month supply of drugs.

In the event of a national or other emergency, you can call HealthPartners Member Services Department at 844-440-1900 to get information on how to get a supply of drugs to meet your needs.

Benefit Description	You Pay	
For Standard Option, a calendar year deductible applies to almost all benefits in this Section. The deductible does not apply to generic formulary drugs.		
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following formulary medications and supplies prescribed by a licensed provider and obtained from a Plan pharmacy or through our designated mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered. • Insulin • Gender affirming drugs. Preferred outpatient products and any authorization requirements are noted in the Drug Formulary • Specialty drugs. Specialty drugs are limited to a 30-day supply. • Oral chemotherapy drugs • Growth hormones	$5 for Tier 1 – Preferred Generic Formulary Drugs $20 for Tier 2 – Generic Formulary Drugs $47 for Tier 3 – Preferred Brand Formulary Drugs 40% coinsurance for Tier 4 – Non-preferred Formulary Drugs 33% coinsurance for Tier 5 – Specialty Formulary Drugs The copayment applies per 30-day supply, or portion thereof You pay no more than $35 per month supply of each covered insulin product, regardless of tier.	In-Network: $5 for Tier 1 – Preferred Generic Formulary Drugs (deductible does not apply) $20 for Tier 2 – Generic Formulary Drugs (deductible does not apply) $47 for Tier 3 – Preferred Brand Formulary Drugs after $590 Part D deductible 40% coinsurance for Tier 4 – Non-preferred Formulary Drugs after $590 Part D deductible 25% coinsurance for Tier 5 – Specialty Formulary Drugs after $590 Part D deductible The copayment applies per 30-day supply, or portion thereof You pay no more than $35 per month supply of each covered insulin product, regardless of tier. Out-of-Network: Specialty drugs: *all charges* All other formulary drugs: 40% of charges after PSHB out-of-network deductible

Covered medications and supplies - continued on next page

Benefit Description	You Pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• Medications prescribed to treat obesity included in the Preferred Rx Drug Formulary Authorization requirements are noted in the Preferred Rx Drug Formulary Note: If you have Part D, see the Medicare Part D Prescription Drug Plan Evidence of Coverage document for information on what's covered under Part D and applies to the out-of-pocket threshold amount.	$5 for low cost generic formulary drugs $25 for high cost generic formulary drugs $75 for preferred brand-name formulary drugs 40% coinsurance for non-preferred brand-name formulary drugs The copayment applies per 30-day supply, or portion thereof	In-Network: $5 for low cost generic formulary drugs (deductible does not apply) $25 for high cost generic formulary drugs (deductible does not apply) $75 for preferred brand-name formulary drugs after PSHB in-network deductible 40% coinsurance for non-preferred brand-name formulary drugs after PSHB in-network deductible The copayment applies per 30-day supply, or portion thereof Out-of-Network: 40% of charges after PSHB out-of-network deductible
• Diabetic supplies included in the Preferred Rx Drug Formulary, limited to: • disposable needles and syringes for the administration of covered medications • blood glucose testing meters and strips • other diabetes supplies such as lancets and pen needles or insulin syringes Note: If you have Part D, see the Medicare Part D Prescription Drug Plan Evidence of Coverage document for information on what's covered under Part D and applies to the out-of-pocket threshold amount.	20% of charges	In-Network: 20% of charges after PSHB in-network deductible Out-of-Network: 40% of charges after PSHB out-of-network deductible
• Special dietary treatment for PKU	20% of charges	In-Network: 20% of charges Out-of-Network: 40% of charges after PSHB out-of-network deductible
• Oral amino acid based elemental formula Note: If you have Part D, see the Medicare Part D Prescription Drug Plan Evidence of Coverage document for information on what's covered under Part D and applies to the out-of-pocket threshold amount.	20% of charges	In-Network: 20% of charges after PSHB in-network deductible Out-of-Network: 40% of charges after PSHB out-of-network deductible

Covered medications and supplies - continued on next page

Benefit Description	You Pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
We cover all FDA approved contraceptive methods as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines, including over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process. Your prescriber will obtain prior approval. Contact Member Services at 844-440-1900 (TTY: 711) for information on this process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Note: For additional Family Planning benefits see Section 5(a) Notes: • Coverage is limited to females (based on sex assigned at birth) • This benefit applies whether the birth control drug or device is used for birth control or for a medically necessary purpose other than birth control. Over-the-counter contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider. These may be purchased at a pharmacy counter.	Nothing for Preferred Rx formulary drugs Nothing if a Provider requests that a Non-Formulary contraceptive drug be dispensed as written	In-Network: Nothing for Preferred Rx formulary drugs; Nothing if a Provider requests that a Non-Formulary contraceptive drug be dispensed as written Out-of-Network: 40% of charges after PSHB out-of-network deductible
Not covered: • *Drugs and supplies for cosmetic purposes* • *Nonprescription (over-the counter) drugs, including, but not limited to vitamins, nutrients, medical foods, food supplements and homeopathic remedies, even if a physician prescribes or administers them, except as specified in this brochure or on the Formulary and prescribed by a physician or legally authorized health care provider under applicable state and federal law.* • *Non-Formulary Drugs, unless a Formulary exception has been granted through the Formulary exception process* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies (High Option only)* • *Medical supplies such as dressings and antiseptics*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You Pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• *Drugs to enhance athletic performance* • *Sexual dysfunction drugs* • *Replacement of prescription drugs, equipment and supplies due to loss, damage or theft* • *Medical cannabis* • *Drugs that are newly approved by the FDA until they are reviewed and coverage is established by HealthPartners Pharmacy and Therapeutics Committee*	*All charges*	*All charges*
Mail order benefits	**High Option**	**Standard Option**
You may also get outpatient formulary prescription drugs which can be self-administered through the designated mail order service. For information on how to obtain drugs through HealthPartners mail order service, please visit www.healthpartners.com/pshb. Specialty drugs are limited to a 30-day supply and may not be available via mail order service. Copayments apply per 90-day supply, or portion thereof	Mail-order pharmacy with preferred cost sharing: $10 for Tier 1 – Preferred Generic Formulary Drugs $40 for Tier 2 – Generic Formulary Drugs $94 for Tier 3 – Preferred Brand Formulary Drugs 40% coinsurance for Tier 4 – Non-preferred Formulary Drugs 33% coinsurance for Tier 5 – Specialty Formulary Drugs Mail-order pharmacy without preferred cost sharing: $15 for Tier 1 – Preferred Generic Formulary Drugs $60 for Tier 2 – Generic Formulary Drugs $141 for Tier 3 – Preferred Brand Formulary Drugs 40% coinsurance for Tier 4 – Non-preferred Formulary Drugs 33% coinsurance for Tier 5 – Specialty Formulary Drugs	Mail-order pharmacy with preferred cost sharing: $10 for Tier 1 – Preferred Generic Formulary Drugs (deductible does not apply) $40 for Tier 2 – Generic Formulary Drugs (deductible does not apply) $94 for Tier 3 – Preferred Brand Formulary Drugs after $590 Part D deductible 40% coinsurance for Tier 4 – Non-preferred Formulary Drugs after $590 Part D deductible 25% coinsurance for Tier 5 – Specialty Formulary Drugs, after $590 Part D deductible Mail-order pharmacy without preferred cost sharing: $15 for Tier 1 – Preferred Generic Formulary Drugs (deductible does not apply) $60 for Tier 2 – Generic Formulary Drugs (deductible does not apply) $141 for Tier 3 – Preferred Brand Formulary Drugs after $590 Part D deductible 40% coinsurance for Tier 4 – Non-preferred Formulary Drugs after $590 Part D deductible 25% coinsurance for Tier 5 – Specialty Formulary Drugs, after $590 Part D deductible Out-of-Network: *all charges*

Benefit Description	You Pay	
Preventive medications	**High Option**	**Standard Option**
Preventive Medications with a USPSTF A and B recommendations as listed on the PSHB Preferred Rx formulary. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco and nicotine dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)	Nothing	In-Network: Nothing Out-of-Network: 40% of charges after PSHB out-of-network deductible
Drugs for breast cancer prevention for individuals at high risk for breast cancer who have not yet been diagnosed with the disease as listed on the PSHB Preferred Rx formulary	Nothing	In-Network: Nothing Out-of-Network: 40% of charges after PSHB out-of-network deductible
Opioid rescue agents, such as naloxone nasal sprays are covered under this Plan. Generic nasal spray (4 mg) is covered with no cost sharing when obtained from a network pharmacy. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/		
Prescription drug benefits - limited benefits	**High Option**	**Standard Option**
Fertility drugs • Limited to products listed on the Preferred Rx Drug Formulary • Fertility drugs used with IVF are limited to three cycles per calendar year Note: If you have Part D, see the Medicare Part D Prescription Drug Plan Evidence of Coverage document for information on what's covered under Part D and applies to the out-of-pocket threshold amount.	40% of charges	In-Network: 40% of charges after PSHB in-network deductible Out-of-Network: All charges

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your PSHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your PSHB Plan. See Section 9, Coordinating benefits with other coverage.
- For Standard Option. For Network Expenses: The calendar year deductible is $750 for persons enrolled for Self Only coverage, $1,500 for persons enrolled for Self Plus One coverage and $1,500 for families enrolled for Self and Family coverage. For Out-of-Network Expenses: The calendar year deductible is $2,000 for persons enrolled for Self Only coverage, $4,000 for persons enrolled for Self Plus One coverage and $4,000 for families enrolled for Self and Family coverage. The calendar year deductible applies to almost all Standard Option benefits in this Section. We added "deductible does not apply" to show when the calendar year deductible does not apply.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient or as required for children who receive anesthesia per our medical policy. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your Cost for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
Accidental injury benefit	**High Option**	**Standard Option**
We cover: • **Accidental dental services In-Network:** Restorative services and supplies provided by Plan dentists necessary to promptly repair or replace sound, natural, unrestored teeth, including the cost and installation of necessary prescription dental prosthetic items or devices. The need for these services must directly result from an accidental injury, not including injury from biting, chewing, clenching or grinding of teeth. Coverage is limited to the initial treatment (or course of treatment) and/or restoration. Only services provided within 24 months from the date of injury are covered. When a dental implant is pursued, reimbursement for the implant and any associated procedures (including bone grafting, implant placement and restoration) is limited to the amount that would be paid toward the fabrication of a removable dental prosthesis. Full mouth rehabilitation to correct occlusion (bite) and malocclusion (misaligned teeth not due to the accident) are not covered.	20% of charges	20% of charges after in-network deductible
• **Emergency accidental dental services Out-of-Network:** Emergency dental services for accidental injury, as described above, when they are provided by Out-of-Network dentists if the injuries require immediate treatment.	30% of charges	30% of charges after in-network deductible

Section 5(h). Wellness and Other Special Features

CareLine® Service

When you call the CareLine service, you reach a skilled nurse who is specially trained to assess medical conditions of all kinds. Call 612-339-3663 or 800-551-0859 and talk with a registered nurse who will discuss treatment options and answer your health questions.

BabyLine Service

If you're an expecting or new parent and have questions after regular clinic hours, our BabyLine service is just for you. The BabyLine service is staffed by obstetric nurses who can help with questions relating to pregnancy, new baby care, nursing, and postpartum concerns. Call 612-333-BABY (333-2229) or 800-845-9297.

Behavioral Health Personalized Assistance Line (PAL)

Our Behavioral Health Personalized Assistance Line (PAL) staff can match you with the network provider that best meets your behavioral health needs. We can identify providers based on:

- Specialty or subspecialty
- Specific diagnostic, language and cultural competence

And if you have an urgent need, we can link you to same day/next day psychiatric appointments. Call 952-883-5811 or 888-638-8787.

Nurse Navigators

Nurse Navigators are experienced nurses who can help research treatment options, coordinate care and guide you through difficult decisions. Call 844-440-1900.

Services for the deaf and hearing impaired

If you are deaf or hearing impaired, call 711

Online tools

As a Plan member, you have instant access to detailed, secured information and helpful services tailored to you. Depending on your coverage, you may be able to:

- View your personal health record
- See your claims information
- View your benefits
- View your medical and dental provider networks
- Find health and wellness information
- Order new ID cards
- Make appointments at HealthPartners Clinics
- Refill a mail order prescription
- Determine the retail and mail order costs of specific drugs
- See all the medications on the HealthPartners preferred list of covered drugs
- Estimate your annual cost of medical care

To access your personalized member page, visit www.healthpartners.com/pshb.

Virtuwell

Virtuwell is an online clinic that treats everyday illnesses so you- or your kids-can get better.

- Quickly and conveniently get care for over 60 common conditions
- get a diagnosis, treatment plan and prescription if needed- all in less than an hour
- you pay nothing. See section 5(a)
- 24/7, with nurse practitioners available

Mobile tools

Download the HealthPartners app or visit the mobile site to find and manage your health plan on-the-go.

Use your smartphone to:

- Access your Member ID card
- Check your plan balances including your deductible
- Search for the closest care locations to you
- Get cost estimates
- View claims and Explanation of Benefits (EOBs)
- …and more

Download the app today in your app store or visit m.healthpartners.com to learn more about HealthPartners mobile offerings, visit www.healthpartners.com/gomobile.

If you have a mobile phone that can get text messages, you can receive a variety of texts from HealthPartners. Either opt in to receive weekly texts or add a phone number in your HealthPartners account to get text specific to you.

Text one of these commands to 77199:

- **DED**: For how much is remaining until you meet your deductible
- **YUM**: For better-for-you eating tips from yumPower
- **FAMILY**: For ideas to support your family's health
- **QUITNOW**: For tips to help you quit smoking

Health assessment and wellness courses

There's no greater reward than living a healthy life. In case you need extra incentive, we've got one for you. When you complete your health assessment and register and complete an eligible online health improvement program, you are entitled to receive a contribution of $250 into your HealthPartners Wellness Account debit card to be used for most qualified medical expenses, prescriptions and IRS 213 (d) vision expenses. For those with Self Plus One or Self and Family coverage, each adult employee or covered spouse, is eligible for the $250 contribution to the HealthPartners Wellness Account. We will send the policyholder two debit cards to access the account. Please keep your card for future use even if you use all of your health account dollars; you may be eligible for wellness incentives in subsequent benefit years. We do not send new cards to continuing participants until the card expires. The account funds must be used by December 31, 2026 or the account will be forfeited.

After completing the online health assessment, you may access online wellness courses to set personalized goals designed to improve your health through increased exercise, healthier nutrition habits, managing your weight, reduced stress, better emotional health, or goals that focus on managing a specific condition. You must complete the health assessment and complete an eligible online health improvement program no later than December 31, 2025 in order to receive these incentives.

Getting rewarded is simple.

- Log into your HealthPartners account at www.healthpartners.com/pshb. If you don't have a username and password, click on "Create an account".
- Take your health assessment.
- Register for an eligible online health improvement program
- Complete the eligible online health improvement program.
- Don't forget, this includes your covered spouse!
- One set of two debit cards will be sent to access the funds in your HealthPartners Wellness Account.

Living Well Activities:

We offer many free programs that may help you with managing weight, dealing with stress, eating better, family health and more:

- Individual phone coaching with a professional health coach
- Group phone coaching with a professional health coach
- Online health programs

Sign in to your HealthPartners account at www.healthpartners.com/pshb for more information.

Healthy Pregnancy program

Start by taking an online assessment at healthpartners.com/pregnancysupport. Based on your answers, you may get a call from a nurse. Our specially-trained team will work with you to answer any questions and give advice between doctor visits. You will also gain access to digital pregnancy content in your HealthPartners account and through email. It's all written by our health experts and timed to where you're at in your pregnancy.

Medicare Premium Reimbursement for High Option members enrolled in both Medicare Parts A and B

High option members enrolled in both Medicare Part A and Part B are eligible to be reimbursed up to $1,200 per calendar year for their Medicare Part B premium payments. Eligible members must have an healthpartners.com/pshb account and notify HealthPartners of their Medicare enrollment status. To receive Part B premium reimbursement, eligible members must submit proof of Part B premium payment no later than March 31 of the following year. For more information on how to get reimbursement for your paid Medicare Part B premiums, please call 844-440-1900 or visit healthpartners.com/pshb/medicare.

Flexible benefits option

Under the flexible benefits option, we determine the most effective way to provide services.

- We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue.
- Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process.
- By approving an alternative benefit, we do not guarantee you will get it in the future.
- The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits.
- If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request.

Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).

Section 5(i). Non-PSHB Benefits Available to Plan Members

The benefits listed in this section are not part of the PSHB contract or premium, and you cannot file a PSHB disputed claim about them. Fees you pay for these services do not count toward PSHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow the Plan's guidelines. For additional information contact the Plan at 844-440-1900 (TTY: 711) or visit www.healthpartners.com/pshb.

For both High Option and Standard Option, HealthPartners is proud to offer value-added services that help members lead healthier lifestyles.

Eyewear discount	You may be eligible for an eyewear discount at Plan optical centers, including HealthPartners Eye Care Centers and EyeMed retailers such as Target, LensCrafters, etc. For more information on the program visit www.healthpartners.com/pshb or call member services at 844-440-1900.
Healthy discounts program	HealthPartners retail savings program gives you discounts on tools and services from reputable organizations to help you be as healthy as you can be. Complete information and list of partner organizations can be found online at www.healthpartners.com/pshb or call member services at 844-440-1900.

Section 6. General Exclusions – Services, Drugs and Supplies We Do Not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services****.*

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan
- Services, drugs, or supplies not medically necessary
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants)
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies you receive from a provider or facility barred from the PSHB Program
- Services, drugs, or supplies you receive without charge while in active military service
  Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.
- Services or supplies we are prohibited from covering under the Federal Law.
- Charges for phone, data, software or mobile applications/apps unless specifically described as covered in our medical coverage criteria for the device or service.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance or deductible.

You will only need to file a claim when you receive services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file a claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 844-440-1900 (TTY: 711), or at our website at www.healthpartners.com/pshb.

When you must file a claim – such as for services you received outside the Plan's Network– submit it on the CMS -1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name, date of birth, address, phone number and ID number
- Name and address of the provider or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

HealthPartners Claims
PO Box 21024
Eagan, MN 55121

Prescription drugs

Submit your PSHB claims to:

HealthPartners Claims
PO Box 21024
Eagan, MN 55121

Submit your PDP EGWP claims to:

HealthPartners Pharmacy Department
P.O. Box 1309
MS 21111B
Minneapolis, MN 55440-1309

Other supplies or services

Submit your claims to:

HealthPartners Claims
PO Box 21024
Eagan, MN 55121

Deadline for filing your claim	Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
Authorized representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a healthcare professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice requirements	If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call us at 844-440-1900 or visit our website at www.healthpartners.com/pshb. If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) and you disagree with our pre-service or post-service decision about your prescription drug benefits, please follow Medicare's appeals process outlined in Section 8(a) of this brochure and Chapter 7 of the Prescription Drug Plan Evidence of Coverage.

Please follow this Postal Service Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing Riverview Member Services, PO Box 21662, Eagan, MN 55121 or calling 844-440-1900 (TTY: 711).

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Riverview Member Rights and Benefits, PO Box 21662, Eagan, MN 55121; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or.

c) Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at:

United States Office of Personnel Management
Healthcare and Insurance, Postal Service Insurance Operations (PSIO)
1900 E Street, NW; Room 3443
Washington, DC 20415

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim;
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM’s review within 60 days. There are no other administrative appeals.

If you do not agree with OPM’s decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 1-888-525-2125. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's PSIO at (202) 936-0002 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Reminder: If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D PDP EGWP you may appeal an adverse pre-service or post-service determination through Medicare's appeals process. See Section 8 (a) of this brochure and chapter 7 of the Prescription Drug Plan Evidence of Coverage.

Section 8(a). Medicare PDP EGWP Disputed Claims Process

When a claim for a Prescription Drug Plan Drug is denied in whole or in part, you may appeal the denial.

Our Plan follows the Medicare Part D appeals process. **This is described in full in chapter 7 of the Prescription Drug Plan Evidence of Coverage.**

Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. For details about Part D drugs, rules, restrictions, and costs please see the Prescription Drug Plan Evidence of Coverage.

This section is about your Part D drugs only.

If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact HealthPartners to ask for a coverage decision.

Part D coverage decisions and appeals

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's List of Covered Drugs
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization, or the requirement to try another drug first)
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier
- Asking to get pre-approval for a drug
- Pay for a prescription drug you already bought

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

What is an exception?

- Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a formulary exception.
- Asking for removal of a restriction on coverage for a drug is sometimes called asking for a formulary exception.
- Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a tiering exception.

If a drug is not covered in the way you would like it to be covered, you can ask us to make an exception. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. Covering a Part D drug for you that is not on our Drug List. If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. Removing a restriction for a covered drug. The Prescription Drug Plan Evidence of Coverage describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing amount we require you to pay for the drug.
3. Changing coverage of a drug to a lower cost-sharing tier. Every drug on our Drug List is in one of five cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

- If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).

- If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
- If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.

You cannot ask us to change the cost-sharing tier for any drug in Tier 5 (Specialty Drugs).

If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called alternative drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception. If you ask us for a tiering exception, we will generally not approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

If we say no to your request, you can ask for another review by making an appeal.

How to ask for a coverage decision, including an exception

<u>Step 1:</u> Decide if you need a standard coverage decision or a fast coverage decision.

Standard coverage decisions are made within 72 hours after we receive your doctor's statement. Fast coverage decisions are made within 24 hours after we receive your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. To get a fast coverage decision, you must meet two requirements:

- You must be asking for a drug you have not yet received. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.
- If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision. If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage
  - Tells you how you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the prescription you want. You can also access the coverage decision process through our website.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf.

If you are requesting an exception, provide the supporting statement, which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

CALL

844-440-1900 or TTY 711

Calls to this number are free.

From **Oct. 1 through March 31**, we take calls from 8 a.m. to 8 p.m. CT, **seven days a week**. You'll speak with a representative.

From **April 1 through Sept. 30**, call us 8 a.m. to 8 p.m. CT, **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day.

FAX

952-853-8700

WRITE

HealthPartners Pharmacy Department
P.O. Box 1309
Mail Stop 21111B
Minneapolis, MN 55440-9463

WEBSITE

healthpartners.com/pshb

We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form*, which is available on our website at Request for Medicare Prescription Drug Coverage Determination form. You may also request a coverage determination electronically. Sign in to your HealthPartners online account at healthpartners.com/pshb to submit an Online Part D Coverage Determination request. Click on the 'forms' link on the My Plan page Overview tab, then scroll down to 'Medicare' to begin. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

Step 3: We consider your request and give you our answer.

Deadlines for a fast coverage decision

We must generally give you our answer within 24 hours after we receive your request.

- For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you have not yet received

We must generally give you our answer within 72 hours after we receive your request.

- For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 72 hours after we receive your request or doctor's statement supporting your request.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

We must give you our answer within 14 calendar days after we receive your request.

- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

If our answer is yes to part or all of what you requested, we are also required to make payment to you within 14 calendar days after we receive your request.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

How to make a Level 1 appeal

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal

- If you are appealing a decision, we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision.

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a **fast appeal.**

- For standard appeals, submit a written request or call us at 844-440-1900.
- For fast appeals either submit your appeal in writing or call us at 844-440-1900.

You must make your appeal request within 65 calendar days from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

You can ask for a copy of the information in your appeal and add more information. You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

CALL

844-440-1900 or TTY 711

Calls to this number are free.

From **Oct. 1 through March 31**, we take calls from 8 a.m. to 8 p.m. CT, **seven days a week**. You'll speak with a representative.

From **April 1 through Sept. 30**, call us 8 a.m. to 8 p.m. CT, **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day.

FAX

952-853-8742

WRITE

HealthPartners Member Rights & Benefits
Mail Stop 21103R
P.O. Box 21662
Eagan, MN 55121

WEBSITE

healthpartners.com/pshb

We must accept any written request, including a request submitted on the CMS Model Redetermination Request Form, which is available on our website at Request a Redetermination of a Medicare Prescription Drug Denial. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.

You may request a coverage redetermination electronically. Sign in to your HealthPartners online account at healthpartners.com/pshb to submit an Online Part D Coverage Redetermination request. Click on the 'Find a form' link on the Medical Plan Services tab, then scroll down to 'Medicare Forms' to begin.

Step 3: We consider your appeal and we give you our answer.

When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request.

We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

For fast appeals, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires it.

If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.6 explains the Level 2 appeal process.

If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you have not yet received

For standard appeals, we must give you our answer within 7 calendar days after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.

If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

If our answer is yes to part or all of what you requested, we must provide the coverage as quickly as your health requires, but no later than 7 calendar days after we receive your appeal.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you have already bought

We must give you our answer within 14 calendar days after we receive your request.

If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

If our answer is yes to part or all of what you requested, we are also required to make payment to you within 30 calendar days after we receive your request.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process. Level 2 of the appeals process is handled through an independent review organization hired by Medicare. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

For additional information on Appeal Levels 2 and beyond, please refer to the Prescription Drug Plan Evidence of Coverage.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at www.NAIC.org.

When we are the secondary payor, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance up to our regular benefit. We will not pay more than our allowance. For example, we will generally only make up the difference between the primary payor's benefits payment and 100% of the Plan allowance, subject to our applicable coinsurance or copayment amounts, except when Medicare is the primary payor (see page 102). Thus, it is possible that the combined payments from both plans may not equal the entire amount billed by the provider.

Note: When we pay secondary to primary coverage you have from a prepaid plan (HMO), we base our benefits on your out-of-pocket liability under the prepaid plan (generally, the prepaid plan's copayments), subject to our coinsurance or copayment amounts. In certain circumstances when we are secondary and there is no adverse effect on you (that is, you do not pay any more), we may also take advantage of any provider discount arrangements your primary plan may have and only make up the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan.

Note: Any visit limitations that apply to your care under this Plan are still in effect when we are the secondary payor. Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage, and you must also send us documents about your other coverage if we ask for them.

Please see Section 4, *Your Costs for Covered Services*, for more information about how we pay claims.

- **TRICARE and CHAMPVA**

TRICARE is the healthcare program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended PSHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these programs, eliminating your PSHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended PSHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these state programs, eliminating your PSHB premium. For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some PSHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your PSHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.gov or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your PSHB plan so that your plans can coordinate benefits. Providing your PSHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes 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 and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "When do I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

Important Note: Subject to limited exceptions, Postal Service annuitants entitled to Medicare Part A and their eligible family members who are entitled to Medicare Part A are required to enroll in Medicare Part B to maintain eligibility for the PSHB Program in retirement.

If you are required to enroll in Medicare Part B and fail to do so at your first opportunity, you may be disenrolled (annuitants) and/or your family members removed from coverage.

For more information on these requirements, please contact the PSHB Helpline at 844-451-1261.

The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare. When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan. When we are the primary payor, we process the claim first. When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 844-440-1900.

To be eligible for full cost-share waiving, members must be enrolled in both Parts A and B of Original Medicare. For members enrolled in High and Standard Option and also enrolled in the Original Medicare Plan (Part A and B) as your primary payor – we will waive your out-of-pocket costs (applicable deductibles, copays and coinsurance) at in-network providers as follows:

- Inpatient hospital benefits: We waive applicable deductibles, copays and coinsurance.

- Medical and surgery benefits and mental health/substance use disorder care: We waive applicable deductibles, copays and coinsurance.
- Office visits: We waive the applicable deductibles, copays and coinsurance at In-Network Providers.
- Physical, speech and occupational therapy benefits: Applicable deductibles, copays and coinsurance is waived.
- Benefit limits and maximums still apply.
- There is no change to your prescription drug coverage. We do not waive deductibles, copays, or coinsurance.
- We do not waive cost-sharing on hearing aids through TruHearing.

You can find more information about how our Plan coordinates benefits with Medicare by calling our PSHB Member Services team at 844-440-1900 or visit healthpartners.com/pshb/medicare.

Cost sharing may not apply if the Original Medicare Plan is your primary payor

– For Medicare covered services we will coordinate benefits to potentially reduce your out-of-pocket costs as follows:

When Medicare Part A is primary –

- You may experience a reduction in cost sharing for our in-network:
  - Annual hospital copayments for Medicare covered services;
  - Hospital coinsurance for Medicare covered services.

Note: Once you have exhausted your Medicare Part A benefits, you must then pay the applicable copayment or coinsurance.

When Medicare Part B is primary –

- You may experience a reduction in cost sharing for our in-network:
  - Coinsurance and copayments for inpatient and outpatient services and supplies provided by physicians and other covered healthcare professionals for Medicare covered services; and
  - Coinsurance and/or copayment for outpatient facility services for Medicare covered services.

Note: We do not waive benefit limitations, such as the 25-visit limit for home nursing visits. In addition, we do not waive any coinsurance or copayments for prescription drugs.

A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. You may be responsible for paying the difference between the billed amount and the amount we paid.

Please review the following information. It illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description: Deductible
High Option You Pay **Without** Medicare: $0
High Option You Pay **With** Medicare Part B: $0
Standard Option You Pay Without Medicare: In-Network: $750/Self Only; $1,500/Self Plus One; $1,500/Family; Out-of-Network: $2,000/Self Only; $4,000/Self Plus One; $4,000/Family
Standard Option You Pay With Medicare: In-Network: $0; Out-of-Network: $2,000/Self Only; $4,000/Self Plus One; $4,000/Family

Benefit Description: Out-of-Pocket Maximum
High Option You Pay **Without** Medicare: Self Only: Nothing after $6,500; Self Plus One: Nothing after $13,000, subject to a maximum of $9,200 per enrollee; Self and Family: Nothing after $13,000, subject to a maximum of $9,200 per enrollee
High Option You Pay **With** Medicare Part B: Self Only: Nothing after $6,500; Self Plus One: Nothing after $13,000, subject to a maximum of $9,200 per enrollee; Self and Family: Nothing after $13,000, subject to a maximum of $9,200 per enrollee
Standard Option You Pay **Without** Medicare: In-Network: Self Only: Nothing after $7,500; Self Plus One: Nothing after $15,000, subject to a maximum of $9,200 per enrollee; Self and Family: Nothing after $15,000, subject to a maximum of $9,200 per enrollee; Out-of-Network: No maximum
Standard Option You Pay **With** Medicare: In-Network: Self Only: Nothing after $7,500; Self Plus One: Nothing after $15,000, subject to a maximum of $9,200 per enrollee; Self and Family: Nothing after $15,000, subject to a maximum of $9,200 per enrollee; Out-of-Network: No maximum

Benefit Description: Part B Premium Reimbursement Offered
High Option You Pay **Without** Medicare: NA
High Option You Pay **With** Medicare Part B: Up to $1,200
Standard Option You Pay **Without** Medicare: NA
Standard Option You Pay **With** Medicare: None

Benefit Description: Primary Care Provider
High Option You Pay **Without** Medicare: $45
High Option You Pay **With** Medicare Part B: Nothing for most Medicare covered services and never more than $45
Standard Option You Pay **Without** Medicare: In-Network: You pay $0 for 5 visits, then 20% after deductible; Out-of-Network: 40% after deductible
Standard Option You Pay **With** Medicare: In-Network: Nothing for most Medicare covered services and never more than 20% after deductible; Out-of-Network: Nothing for most Medicare covered services and never more than 40% after deductible

Benefit Description: Specialist
High Option You Pay **Without** Medicare: $45
High Option You Pay **With** Medicare Part B: Nothing for most Medicare covered services and never more than $45
Standard Option You Pay **Without** Medicare: In-Network: 20% after deductible; Out-of-Network: 40% after deductible
Standard Option You Pay **With** Medicare: In-Network: Nothing for most Medicare covered services and never more than 20% after deductible; Out-of-Network: Nothing for most Medicare covered services and never more than 40% after deductible

Benefit Description: Inpatient Hospital
High Option You Pay **Without** Medicare: $500 hospital deductible for inpatient & outpatient combined, then 20% of charges
High Option You Pay **With** Medicare Part B: Nothing for most Medicare covered services and never more than a $500 hospital deductible for inpatient & outpatient combined, then 20% of charges
Standard Option You Pay **Without** Medicare: In-Network: 20% after deductible; Out-of-Network: 40% after deductible
Standard Option You Pay **With** Medicare: In-Network: Nothing for most Medicare covered services and never more than 20% after deductible; Out-of-Network: Nothing for most Medicare covered services and never more than 40% after deductible

Benefit Description: Outpatient Surgery - Hospital
High Option You Pay **Without** Medicare: $500 hospital deductible for inpatient & outpatient combined, then 20% of charges
High Option You Pay **With** Medicare Part B: Nothing for most Medicare covered services and never more than a $500 hospital deductible for inpatient & outpatient combined, then 20% of charges
Standard Option You Pay **Without** Medicare: In-Network: 20% after deductible; Out-of-Network: 40% after deductible
Standard Option You Pay **With** Medicare: In-Network: Nothing for most Medicare covered services and never more than 20% after deductible; Out-of-Network: Nothing for most Medicare covered services and never more than 40% after deductible

Benefit Description: Incentives Offered
High Option You Pay **Without** Medicare: N/A
High Option You Pay **With** Medicare Part B: Health assessment and wellness courses. For more information see page 80
Standard Option You Pay **Without** Medicare: N/A
Standard Option You Pay **With** Medicare: Health assessment and wellness courses. For more information see page 80

You can find more information about how our plan coordinates benefits with Medicare by visiting www.healthpartners.com/pshb.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare prescription drug coverage (Part B)**

This health plan does not coordinate its prescription drug benefits with Medicare Part B.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227) (TTY: 877-486-2048) or at www.medicare.gov or call us at 844-440-1900 (TTY: 711) or see our website at www.healthpartners.com/pshb.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another non-PSHB plan's Medicare Advantage plan and also remain enrolled in our PSHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended PSHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant, you can suspend your PSHB coverage to enroll in a Medicare Advantage plan, eliminating your PSHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

  When we are the primary payor, we process the claim first. If you (as an active employee eligible for Medicare Part D or their covered Medicare Part D-eligible family member) enroll in any open market Medicare Part D plan and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by that Medicare Part D plan and consider them for payment under the PSHB plan.

  Note: If you are a Postal Service annuitant or their covered Medicare-eligible family member enrolled in our Medicare Part D PDP EGWP, this does not apply to you because you may not be enrolled in more than one Medicare Part D plan at the same time. If you opt out of or disenroll from our PDP EGWP you do not have our PSHB Program prescription drug coverage and we are not a secondary payor for prescription drug benefits.

- **Medicare prescription drug coverage (Part D) out-of-pocket maximum**

  If you are enrolled in the HealthPartners PDP, when your Part D prescription drug copayments and/or coinsurance total $2,000 in a calendar year, you do not have to pay any more for covered Part D prescription drugs for the remainder of that calendar year.

- **Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP)**

  If you are enrolled in Medicare Part A and/or Part B, you will be automatically group enrolled into our Medicare PDP EGWP. Our PDP EGWP is a prescription drug benefit for Postal Service annuitants and their covered Medicare-eligible family members. This allows you to receive benefits that will never be less than the standard prescription drug coverage that is available to members with non-PDP EGWP prescription drug coverage. But more often you will receive benefits that are better than members with standard non-PDP EGWP prescription drug coverage. **Note: You have the choice to opt out of or disenroll from our PDP EGWP at any time and may obtain prescription drug coverage outside of the PSHB Program.**

  When you are enrolled in our Medicare PDP EGWP for your prescription drug benefits you continue to have our medical coverage.

  Members with higher incomes may have a separate premium payment for their Medicare Part D Prescription Drug Plan (PDP) benefit. Please refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to an additional premium.

  For people with limited income and resources, Extra Help is a Medicare program to help with Medicare prescription drug plan costs. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213 TTY 800-325-0778. You may also contact HealthPartners Member Services at 844-440-1900.

  The PDP EGWP opt out process:
  If you were automatically group enrolled into our PDP EGWP and choose to opt out, contact us at 844-440-1900.

  The PDP EGWP disenrollment process:
  When you are enrolled in our PDP EGWP, you may choose to disenroll at any time. To opt-out of enrollment in the PDP, call Member Services at 844-440-1900.

  Warning: If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage.

  Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll when and if you are eligible. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance at 844-440-1900.

Members enrolled in the HealthPartners PDP combined with our High Option plan will have reduced cost-sharing for some Part D drugs.
Tier 1 – Preferred Generic Drugs: $5 copay
Tier 2 – Generic Drugs: $20 copay
Tier 3 – Preferred Brand Drugs: $47 copay
Tier 4 – Non-preferred Drugs: 40% coinsurance
Tier 5 – Specialty Drugs: 33% coinsurance
Part D Annual Out-of-Pocket Maximum: $2,000

Members enrolled in the HealthPartners PDP combined with our Standard Option plan will have reduced cost-sharing for some Part D drugs.
Deductible: $590
Tier 1 – Preferred Generic Drugs: $5 copay
Tier 2 – Generic Drugs: $20 copay
Tier 3 – Preferred Brand Drugs: $47 copay after deductible
Tier 4 – Non-preferred Drugs: 40% coinsurance after deductible
Tier 5 – Specialty Drugs: 25% coinsurance after deductible
Part D Annual Out-of-Pocket Maximum: $2,000

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have PSHB coverage on your own as an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have PSHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Postal Service and your position is excluded from the PSHB (your employing office will know if this is the case) and you are not covered under PSHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Postal Service and your position is not excluded from the PSHB (your employing office will know if this is the case) and...		
• You have PSHB coverage on your own or through your spouse who is also an active employee		✓
• You have PSHB coverage through your spouse who is an annuitant	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a Postal employee receiving Workers' Compensation		✓*
8) Are a Postal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30-month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30-month coordination period)**		✓
• Medicare based on ESRD **(after the 30-month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have PSHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical trials cost categories

An approved clinical trial includes 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 and is either Federally funded; conducted under an investigational new drug application review by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

See Section 4, page 23

Copayment

See Section 4, page 23

Cost-sharing

See Section 4, page 23

Covered services

Care we provide benefits for, as described in this brochure.

Deductible

See Section 4, page 23

Durable Medical Equipment (DME)

This is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

Experimental or investigational service

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

- There is final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the United States Food and Drug Administration (FDA); and

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

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

Healthcare professional — A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.

Infertility — Infertility is the failure to achieve a successful pregnancy after regular, unprotected intercourse or artificial insemination for 12 months or more (6 months for individuals with female reproductive organs over age 35). Evaluation may be justified based on medical history and diagnostic testing. Infertility may also be established through an evaluation based on medical history and diagnostic testing.

Medical necessity — This plan defines medically necessary care as care that is appropriate for the condition, including those related to mental health. It includes the kind and level of service. It includes the number of treatments. It also includes where you get the service and how long it continues. Medically necessary care must:

- Be the service that other providers would usually order
- Help you get better, or stay as well as you are
- Help stop the condition from getting worse
- Help prevent and find health problems

Medicare Part A — Part A helps cover inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care.

Medicare Part B — Part B covers medically necessary services like doctors' services and tests, outpatient care, home health services, durable medical equipment, and other medical services.

Medicare Part C — Part C is a Medicare Advantage plan that combines the coverage of Medicare Part A and Part B. Part C typically also covers additional benefits like, dental, vision, and hearing services. Some Part C plans also include Medicare Part D coverage.

Medicare Part D

Medicare Part D plans provide coverage for prescription drugs. Private insurers contract with CMS on an annual basis for the right to offer Part D plans. Part D can be offered as a standalone Prescription Drug Plan (PDP) or as part of a Medicare Advantage Prescription Drug Plan (MAPD).

Medicare Part D EGWP

A Medicare Part D Employer Group Waiver Plan (EGWP) is a type of Medicare prescription drug plan that can be offered to employees and retirees of certain companies, unions, or government agencies, which allows for flexibility and enhanced coverage of traditional Medicare pharmacy benefits. Examples of Medicare Part D EGWPs are Medicare Advantage Prescription Drug (MAPD) plan EGWPs that include both health and drug benefits, as well as Prescription Drug Plan (PDP) EGWPs, which only cover the prescription drug benefit.

Over-the-Counter (OTC)

These are items, medical equipment or medicines available without a prescription.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways.

You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.

We determine our allowance as follows:

- For covered services delivered by Plan providers, Plan referral providers, or out-of-network providers that have a contract with us, our allowance is the provider’s contracted rate for a given medical/surgical service, procedure or item, which Plan providers have agreed to accept as payment in full.
- For covered services delivered by non-Plan providers that do not have a contract with us, our allowance is the provider’s charge for a given medical/surgical service, procedure or item, according to the usual and customary charge amount.
- The usual and customary charge is the maximum amount allowed that we consider 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 deductible or catastrophic protection out-of-pocket maximum

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require prior approval, or a referral and (2) where failure to obtain prior approval, or a referral results in a reduction of benefits.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a worker's compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Surprise bill

An unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Urgent care claims

A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve pre-service claims and post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our customer service department. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and we have the same meaning as HealthPartners and its related organizations.

Usual and Customary Charge

The usual and customary charge is the maximum amount allowed that we consider in the calculation of the payment of charges incurred for certain covered services received from Out-of-Network providers. It is consistent with the range of reasonable fees charged by other providers of a given service or item in the same geographic region.

The usual and customary charge is determined using one of the following options in the following order, depending on availability: 1) a percentage of the Medicare fee schedule; 2) a comparable schedule if the service is not on the Medicare fee schedule; or 3) a commercially reasonable rate for such service.

You must pay for any charges above the usual and customary charge, and they do not apply to the deductible or catastrophic protection out-of-pocket maximum.

You

You refers to the enrollee and each covered family member.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of Benefits for 2025 High Option

- Do not rely on this chart alone. All benefits are subject to the definitions, limitations and exclusions in this brochure. You can obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.healthpartners.com/pshb.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option	You pay	Page
Medical services provided by physicians: • **Diagnostic and treatment services provided in the office, urgent care and convenience clinic and by evisit and telephone**	$10 per convenience clinic visit; $45 per office visit; $45 per urgent care visit; nothing for Virtuwell evisits	29
• **Virtuwell**	Nothing	29
Services provided by a hospital: • **Inpatient and Outpatient**	$500 hospital deductible for inpatient & outpatient combined, then 20% of charges	57
Emergency benefits: • **In-area and out-of-area**	$250 per emergency room visit; $45 per office or urgent care center visit	62
Mental health and substance use disorder treatment	Regular cost-sharing	64
Prescription drugs: • **Retail pharmacy (generally a 30-day supply)**	$5 for low cost generic formulary drugs; $25 for high cost generic formulary drugs; $75 for preferred brand-name formulary drugs; 40% coinsurance for non-preferred brand-name formulary drugs	67
• **Mail order service (generally a 90-day supply)**	$10 for low cost generic formulary drugs; $50 for high cost generic formulary drugs; $150 for preferred brand-name formulary drugs; 40% coinsurance for non-preferred brand-name formulary drugs	70
• **Specialty drugs**	40% coinsurance for specialty drugs	67
• **Medicare PDP EGWP**	Tier 1 – Preferred Generic Drugs: $5 copay; Tier 2 – Generic Drugs: $20 copay; Tier 3 – Preferred Brand Drugs: $47 copay; Tier 4 – Non-preferred Drugs: 40% coinsurance; Tier 5 – Specialty Drugs: 33% coinsurance; Part D Annual Out-of-Pocket Maximum: $2,000	74
Dental care: • **Accidental injury**	20% of charges, if Network dentist provides care; 30% of charges when provided by Out-of-Network dentist if the injuries require immediate treatment.	79
Vision care	Nothing for preventive care	43

High Option	You pay	Page
Protection against catastrophic costs (out-of-pocket maximum):	**Self Only:** Nothing after $6,500; **Self Plus One:** Nothing after $13,000, subject to a maximum of $9,200 per enrollee; **Self and Family:** Nothing after $13,000, subject to a maximum of $9,200 per enrollee	24
Special features:	CareLine® service, Nurse Navigator, Behavioral Health Personalized Assistance Line, special phone lines for deaf and hearing impaired, personalized member page on website, health improvement programs	80

Summary of Benefits for 2025 Standard Option

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations and exclusions in this brochure. You can obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.healthpartners.com/pshb.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Standard Option	You pay	Page
Medical services provided by physicians: • **Diagnostic and treatment services provided in the office, urgent care and convenience clinic and by evisit and telephone**	In-Network: $0 for 5 visits, then 20% after in-network deductible Out-of-Network: 40% after out-of-network deductible	29
• **Virtuwell**	Nothing	29
Services provided by a hospital: • **Inpatient and Outpatient**	In-Network: 20% after in-network deductible Out-of-Network: 40% after out-of-network deductible	57
Emergency outpatient hospital benefits • **In-area and out-of-area**	20% after in-network deductible	62
Mental health and substance use disorder treatment	Regular cost-sharing	64
Prescription drugs: • **Retail pharmacy (generally a 30-day supply)**	In-Network: $5 for low cost generic formulary drugs; $25 for high cost generic formulary drugs; $75 for preferred brand name formulary drugs after in-network deductible; 40% coinsurance for non-preferred brand-name formulary drugs after in-network deductible. Out-of-Network: 40% after out-of-network deductible.	67
• **Mail order service (generally a 90-day supply)**	In-Network: $10 for low cost generic formulary drugs; $50 for high cost generic formulary drugs; $150 for preferred brand name formulary drugs after in-network deductible; 40% coinsurance for non-preferred brand-name formulary drugs after in-network deductible. Out-of-Network: all charges.	70
• **Specialty drugs**	In-Network: 40% coinsurance for specialty drugs, after in-network deductible Out-of-Network: All charges	67
• **Medicare PDP EGWP**	Deductible: $590; Tier 1 – Preferred Generic Drugs: $5 copay; Tier 2 – Generic Drugs: $20 copay; Tier 3 – Preferred Brand Drugs: $47 copay after deductible; Tier 4 – Non-preferred Drugs: 40% coinsurance after deductible; Tier 5 – Specialty Drugs: 25% coinsurance after deductible; Part D Annual Out-of-Pocket Maximum: $2,000	74
Dental care: • **Accidental injury**	In-Network: 20% after in-network deductible. Out-of-Network: 30% after in-network deductible.	79
Vision care	Nothing for preventive care	43

Standard Option	You pay	Page
Protection against catastrophic costs (out-of-pocket maximum)	**In-Network: Self Only:** Nothing after $7,500; **Self Plus One:** Nothing after $15,000, subject to a maximum of $9,200 per enrollee; **Self and Family:** Nothing after $15,000, subject to a maximum of $9,200 per enrollee; **Out-of-Network:** no maximum	24
Special features:	CareLine® service, Nurse Navigator, Behavioral Health Personalized Assistance Line, special phone lines for deaf and hearing impaired, personalized member page on website, health improvement programs	80

2025 Rate Information for HealthPartners

To compare your PSHB health plan options please go to https://health-benefits.opm.gov/PSHB/.

To review premium rates for all PSHB health plan options please go to **https://www.opm.gov/healthcare-insurance/pshb/premiums/**.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
High Option - Self Only	KGA	$286.09	$97.24	$619.86	$210.69
High Option - Self Plus One	KGC	$618.40	$228.76	$1,339.87	$495.64
High Option - Self and Family	KGB	$672.95	$260.85	$1,458.06	$565.17
Standard Option - Self Only	KGD	$191.52	$63.84	$414.96	$138.32
Standard Option - Self Plus One	KGF	$423.27	$141.09	$917.09	$305.69
Standard Option - Self and Family	KGE	$466.56	$155.52	$1,010.88	$336.96