Amendment to the HealthPartners Medical Benefit Plan
Summary Plan Description

Keep this Amendment with your Summary Plan Description

Group Name: Carleton College
Group Number: 28110
Effective Date: The later of January 1, 2022 and your effective date for coverage under the HealthPartners Medical Benefit Plan

Your Summary Plan Description is amended as follows:

1. Effective through the end of the national public health emergency, coverage for the testing of COVID-19 and the associated provider visit will be covered at no cost. Services may be performed by a Network or Non-Network Provider.

2. Effective through the end of the national public health emergency, the following exceptions will be made:
   - If a Covered Person is transferred from a Network hospital that lacks capacity due to the COVID-19 pandemic to another facility that has capacity, medical transportation from the Network hospital to an available facility will be covered at no cost.
   - If a Covered Person is transferred from a Network hospital that lacks capacity due to the COVID-19 pandemic to another facility that has capacity, and is transferred to a hospital that is a Non-Network hospital, the Non-Network hospital will be covered at the same benefit level that would have applied had the Covered Person received services from a Network hospital.
   - Antibody therapy for COVID-19 administered at Non-Network antibody infusion sites and/or by Non-Network Providers which administer the therapy, will be covered at the same benefit level as a Network site or Provider.

3. In “INTRODUCTION TO THE SUMMARY PLAN DESCRIPTION”, under “ABOUT THE NETWORK”, “Continuity of Care” is replaced by the following:

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

   The following conditions qualify for this benefit:
   - an acute condition;
   - a life-threatening mental or physical illness;
   - pregnancy for which you have begun care;
   - a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; 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 Covered Person’s life if a physician, advanced practice registered nurse, or physician assistant certifies that the Covered Person has an expected lifetime of 180 days or less.
Continuity of care benefits will not be available or may be discontinued if the provider is terminated from the network for misconduct.

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

4. **In “ELIGIBILITY AND EFFECTIVE DATE”, the following is added to the “SPECIAL ENROLLMENT PERIOD” subsection:**

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

5. **In the “BENEFITS CHART”, the introductory provisions are replaced by the following:**

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

To be covered under this Plan, the medical or dental services or items described below must be medically necessary or dentally necessary.

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

Covered Services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. Covered prescription drugs are based on requirements established by the HealthPartners Pharmacy and Therapeutics Committee, and are subject to periodic review and modification. The Medical Coverage Criteria and formulary requirements are available by logging on to your “myHealthPartners” account at healthpartners.com or by calling Member Services.

Coverage may vary according to your network or provider selection.

Non-Network Providers: Except for air ambulance, emergency care, certain post-stabilization care, and certain non-emergency services from Non-Network Providers at certain Network facilities as required under the federal No Surprises Act and its implementing regulations, when you use Non-Network Providers, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses. A Non-Network Provider may not have an agreement with HealthPartners to provide services at the discounted fee. In the absence of a contracted rate, Non-Network Benefits are restricted to the usual and customary amount as described under the definition of “Charge.” If the Non-Network Provider’s billed charges are over the usual and customary amount, you pay the difference, in addition to any required deductible, copayment and/or coinsurance, and these charges do not apply to the out-of-pocket limit.

6. **In the “BENEFITS CHART”, the definition of Charge is replaced with the following:**

**Charge:**

For Covered Services delivered by participating Network Providers or Non-Network Providers that have a contract with the Plan Manager, this is the provider's contracted rate for a given medical/surgical service, procedure or item.

For Covered Services delivered by Non-Network Providers that do not have a contract with the Plan Manager, this is the usual and customary charge. The usual and customary charge is determined using the following options in the following order depending on availability: (1) 140% of the Medicare fee schedule; (2) a comparable schedule if the service is not available on the Medicare fee schedule; or (3) a commercially reasonable rate for such service.

A charge is incurred for covered ambulatory medical, inpatient professional fees, and surgical services on the date the service or item is provided. A charge is incurred for covered inpatient facility fees on the date of admission to a hospital. To be covered, a charge must be incurred on or after the Covered Person's effective date and on or before the termination date.
7. In the “BENEFITS CHART”, “AMBULANCE AND MEDICAL TRANSPORTATION” is replaced with the following:

AMBULANCE AND MEDICAL TRANSPORTATION

Covered Services:
The Plan covers ground ambulance, fixed wing air ambulance and rotary wing air ambulance for medical emergencies.
The Plan also covers ground ambulance, fixed wing air ambulance and rotary wing air ambulance for non-emergency medical transportation if it meets the Medical Coverage Criteria.
Non-emergency fixed wing air ambulance requires prior authorization.
Covered Services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. The Medical Coverage Criteria and applicable prior authorization requirements are available by logging on to your “myHealthPartners” account at healthpartners.com or by calling Member Services.

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>75% of the charges incurred, after you pay the deductible.</td>
<td>75% of the charges incurred, after you pay the Network deductible. Subject to the Network out-of-pocket limit. The amount you pay for these services will be determined based on the requirements of the No Surprises Act and its implementing regulations.</td>
</tr>
</tbody>
</table>

8. In the “BENEFITS CHART”, a new section “AUTISM SERVICES” is added:

AUTISM SERVICES

Covered Services:
For children under the age of 18, the Plan covers the diagnosis, evaluations and multidisciplinary assessment of autism spectrum disorders. The Plan covers medically necessary care including, but not limited to, the following:

• early intensive behavioral and developmental therapy based in behavioral and developmental science, including, but not limited to, all types of applied behavior analysis, intensive early intervention behavior therapy and intensive behavior intervention;
• neurodevelopmental and behavioral health treatments and management;
• speech therapy;
• occupational therapy;
• physical therapy; and
• medications.

The diagnosis, evaluation and assessment includes an assessment of the child’s developmental skills, functional behavior, needs and capacities. Treatment must be in accordance with an individualized treatment plan prescribed by the Covered Person’s treating physician or mental health professional.
The Plan can request an updated treatment plan no more frequently than once every six months, unless we and your attending physician agree earlier review is necessary due to emerging circumstances.
An independent progress evaluation conducted by a mental health professional with expertise and training in autism spectrum disorder and child development must be completed to determine whether progress is being made toward function and generalizable goals, set forth in the treatment plan.
Coverage for physical therapy, occupational therapy and speech therapy are covered under the “Physical Therapy, Occupational Therapy and Speech Therapy” section. Coverage for medications are covered under the “Prescription Drug Services” section.
Covered Services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. The Medical Coverage Criteria are available by logging on to your “myHealthPartners” account at healthpartners.com or by calling Member Services.

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50 copayment and 100% thereafter per visit.</td>
<td>60% of the charges incurred, after you pay the deductible.</td>
</tr>
<tr>
<td>Deductible does not apply.</td>
<td></td>
</tr>
</tbody>
</table>

**Not Covered:**
- Please refer to the “SERVICES NOT COVERED” section.

9. Under “BEHAVIORAL HEALTH SERVICES”, in the subsection “Mental Health Services”, the item “Inpatient Services, including Psychiatric Residential Treatment for Emotionally Disabled Children” is replaced by the following:

**Inpatient services, including mental health residential treatment services.** The Plan covers the following:
- Medically necessary inpatient services in a hospital and professional services for treatment of mental health disorders. Medical stabilization is covered under inpatient hospital services in the “Hospital and Skilled Nursing Facility Services” section; and
- Medically necessary mental health residential treatment services. This care must be prior authorized by HealthPartners and provided by a hospital or residential behavioral health treatment facility licensed by the local state or Department of Health and Human Services.

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

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>75% of the charges incurred, after you pay the deductible.</td>
<td>60% of the charges incurred, after you pay the deductible.</td>
</tr>
</tbody>
</table>

10. In the “BENEFITS CHART”, “EMERGENCY AND URGENTLY NEEDED CARE SERVICES” is replaced with the following:

**EMERGENCY AND URGENTLY NEEDED CARE SERVICES**

**Urgently needed care services**

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

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

**Urgently Needed Care at Clinics**

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50 copayment and 100% thereafter per visit.</td>
<td>60% of the charges incurred, after you pay the deductible.</td>
</tr>
<tr>
<td>Deductible does not apply.</td>
<td></td>
</tr>
</tbody>
</table>

**Emergency care services**

**Covered Services:**
These are services to treat: (1) the sudden, unexpected onset of illness or injury which, if left untreated or unattended until the next available clinic or office hours, would result in hospitalization; or (2) a condition requiring professional health services immediately necessary to preserve life or stabilize health. Emergency care includes emergency services as defined in Division BB, Title I, Section 102 of the Consolidated Appropriations Act of 2021.
When reviewing claims for coverage of emergency services, the Plan’s medical director will take into consideration (1) whether a reasonable layperson would believe that the circumstances required immediate medical care that could not wait until the next available clinic appointment or be treated through urgent care; (2) the time of day and day of the week the care was provided; and (3) the presenting symptoms, including but not limited to severe pain, to ensure that the decision to reimburse the emergency care is not made solely on the basis of the actual diagnosis.

**Emergency Care in a Hospital Emergency Room, including Professional Services of a Physician**

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>75% of the charges incurred, after you pay the deductible.</td>
<td>75% of the amount determined under the law, after you pay the Network deductible. Subject to the Network out-of-pocket limit.</td>
</tr>
<tr>
<td></td>
<td>The amount you pay for these services will be determined based on the requirements of the No Surprises Act and its implementing regulations.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>75% of the charges incurred, after you pay the deductible.</td>
<td>75% of the amount determined under the law, after you pay the Network deductible. Subject to the Network out-of-pocket limit.</td>
</tr>
<tr>
<td>Non-Network professional fees will be paid at the Network Inpatient Hospital Services Benefit level if the covered person is admitted inpatient to a network hospital through the emergency room.</td>
<td>The amount you pay for these services will be determined based on the requirements of the No Surprises Act and its implementing regulations.</td>
</tr>
</tbody>
</table>

Not Covered:
- Please refer to the “SERVICES NOT COVERED” section.

11. In “SERVICES NOT COVERED”, the following exclusion is deleted:

49. Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders, including ABA, IEIBT, and Lovaas.

12. The following is added to the “CONTINUATION OF GROUP COVERAGE” section:

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

13. The following is added to the “CLAIMS PROCEDURES” section:

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

14. In “SPECIFIC INFORMATION ABOUT THE PLAN”, the item “Plan Identification Number” is changed from “501” to “508”.

This Amendment does not change, alter or amend any of the other provisions or limitations of the Summary Plan Description. In all other respects the Summary Plan Description shall, except to the extent explicitly amended hereby, remain in full force and effect.