MINNESOTA EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	HealthPartners, Inc.
Product Name	Small Group Product
Plan Name	500 25 Open Access
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (FEDVIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	Yes

BENEFITS AND LIMITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	**Primary Care Visit to Treat an Injury or Illness**	Covered	Office Visits for Illness or Injury	No							No
2	**Specialist Visit**	Covered	Specialist Visit	No							No
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Other Practitioner Office Visit (Nurse, Physician Assistant)	No							No
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Outpatient Hospital	No							No
5	**Outpatient Surgery Physician/Surgical Services**	Covered	Outpatient Surgery	No							No
6	**Hospice Services**	Covered	Home Hospice Services	Yes	30	Days per year			Excludes financial or legal counseling services; or housekeeping or meal services in the patient's home; or custodial care related to hospice services, whether provided in the home or in a nursing house; or any service not specifically described as covered services under the home hospice services benefits; or any services provided by a members of the patient's family or residents in the member's home.	Respite care is limited to 5 days per episode.	No
7	**Non-Emergency Care When Traveling Outside the U.S.**	Covered	Non-Emergency Care when traveling outside the U.S.	No							No
8	**Routine Dental Services (Adult)**	Not Covered									
9	**Infertility Treatment**	Not Covered									
10	**Long-Term/Custodial Nursing Home Care**	Not Covered									
11	**Private-Duty Nursing**	Not Covered									
12	**Routine Eye Exam (Adult)**	Covered	Routine Eye Exam	No							No
13	**Urgent Care Centers or Facilities**	Covered	Urgent Care Centers	No							No

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14	**Home Health Care Services**	Covered	Home Health Services	Yes	120	Visits per year					No
15	**Emergency Room Services**	Covered	Emergency Room Services	No							No
16	**Emergency Transportation/ Ambulance**	Covered	Ambulance and medical Transportation	No							No
17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient Hospital Services	Yes	365	Other	Day maximum per period of confinement				No
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient Physicians and Surgical Services	Yes	365	Other	Day maximum per period of confinement				No
19	**Bariatric Surgery**	Not Covered									
20	**Cosmetic Surgery**	Not Covered									
21	**Skilled Nursing Facility**	Covered	Skilled Nursing Facility	Yes	120	Days per admission			Custodial Care is not covered.		No
22	**Prenatal and Postnatal Care**	Covered	Routine Prenatal and Postnatal Care	No							No
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Inpatient Hospital Delivery and Maternity Care	No							No
24	**Mental/Behavioral Health Outpatient Services**	Covered	Behavioral Health/Mental Health Outpatient Services	No							No
25	**Mental/Behavioral Health Inpatient Services**	Covered	Behavioral Health/Mental Health Inpatient Services	Yes	365	Other	Day maximum per period of confinement				No
26	**Substance Abuse Disorder Outpatient Services**	Covered	Chemical Health Outpatient Services	No							No
27	**Substance Abuse Disorder Inpatient Services**	Covered	Chemical Health Inpatient Services	Yes	365	Other	Day maximum per period of confinement				No
28	**Generic Drugs**	Covered	Prescription Drug Generic Formulary Drugs	No							No
29	**Preferred Brand Drugs**	Covered	Prescription Drug Brand Formulary Drugs	No							No

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30	**Non-Preferred Brand Drugs**	Covered	Prescription Drug Non-Formulary Drugs	No							No
31	**Specialty Drugs**	Covered	Specialty Drugs	No							No
32	**Outpatient Rehabilitation Services**	Covered	Rehabilitative Care	No							No
33	**Habilitation Services**	Covered	Habilitative Care	No							No
34	**Chiropractic Care**	Covered	Chiropractic Services	No							No
35	**Durable Medical Equipment**	Covered	Durable Medical Equipment	No					Equipment and supplies must be obtained from or repaired by approved vendors. Diabetic supplies and equipment are limited to certain models and brands. PKU and oral amino acid based formulas must meet medical coverage criteria. Payment will not exceed the cost of an alternative piece of equipment or service that is effective and medically necessary. We reserve the right to determine if an item will be approved for rental vs. purchase. Replacement or repair of any cover items if they are damaged or destroyed by member misuse, abuse or carelessness, lost or stolen. Duplicate or similar items. Labor and related charges for repair which are more than the cost of replacement by an approved vendor. Sales tax, mailing, delivery charges, services call charges. Items for education, hygiene, vocation, comfort, convenience or recreation. Communication aids or devices. Household equipment which primary has customary uses other than medical. Household fixtures. Modification to the structure of the home. Vehicle, car or van modifications. Rental equipment while member's owned equipment is being repaired by non-contracted vendors, beyond one month rental. Other equipment and supplies that we determine are not eligible for coverage.		No

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36	**Hearing Aids**	Covered	Hearing Aid	Yes	1	Other	1 every three years		Coverage is only for indicated in explanation.	Must be 18 years or younger and have hearing loss that is not corrected by other covered procedures. (State Mandate Coverage Only).	No
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Laboratory and Diagnostic Imaging Services	No							No
38	**Imaging (CT/PET Scans, MRIs)**	Covered	MRI and CT	No							No
39	**Preventive Care/ Screening/ Immunization**	Covered	Preventive Services	No							No
40	**Routine Foot Care**	Not Covered									
41	**Acupuncture**	Not Covered									
42	**Weight Loss Programs**	Not Covered									
43	**Routine Eye Exam for Children**	Covered	Routine eye exam	Yes	1	Visits per year					No
44	**Eye Glasses for Children**	Covered	Eyeglasses for adults and children	Yes	1	Other	1 pair of glasses (lenses and frames per year				No
45	**Dental Check-Up for Children**	Covered	Dental Exams	Yes	1	Other	1 every 6 months			Limitations, including dollar limits, may apply.	No

OTHER BENEFITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	**Other**	Covered	Online Convenience Care	No						Follows E-visit benefit.	No
2	**Other**	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
3	**Other**	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply.	No
4	**Other**	Covered	Orthodontia - Child	No						Limitations, including dollar limits, may apply.	No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	13
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	4
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	5
ANESTHETICS	LOCAL ANESTHETICS	2
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	3
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS	1
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	3
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	1
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	13
ANTIBACTERIALS	AMINOGLYCOSIDES	4
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	10
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	6
ANTIBACTERIALS	BETA-LACTAM, OTHER	1
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	5
ANTIBACTERIALS	MACROLIDES	4
ANTIBACTERIALS	QUINOLONES	4
ANTIBACTERIALS	SULFONAMIDES	3
ANTIBACTERIALS	TETRACYCLINES	4
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	1
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	2
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	5
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	5
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	0
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	3
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	6
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	2
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	6
ANTIDEPRESSANTS	TRICYCLICS	6
ANTIEMETICS	ANTIEMETICS, OTHER	7
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	2
ANTIFUNGALS	NO USP CLASS	13
ANTIGOUT AGENTS	NO USP CLASS	5
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	1
ANTIMIGRAINE AGENTS	PROPHYLACTIC	2

CATEGORY	CLASS	SUBMISSION COUNT
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	4
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	1
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2
ANTIMYCOBACTERIALS	ANTITUBERCULARS	4
ANTINEOPLASTICS	ALKYLATING AGENTS	5
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	2
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	2
ANTINEOPLASTICS	ANTIMETABOLITES	2
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	1
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3
ANTINEOPLASTICS	ENZYME INHIBITORS	1
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	11
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0
ANTINEOPLASTICS	RETINOIDS	1
ANTIPARASITICS	ANTHELMINTICS	4
ANTIPARASITICS	ANTIPROTOZOALS	5
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	2
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	2
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	2
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	3
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	2
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	1
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	9
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	5
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1
ANTISPASTICITY AGENTS	NO USP CLASS	3
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	2
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	5
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	11
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	3
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9
ANTIVIRALS	ANTI-INFLUENZA AGENTS	4
ANTIVIRALS	ANTIHEPATITIS AGENTS	11
ANTIVIRALS	ANTIHERPETIC AGENTS	2
ANXIOLYTICS	ANXIOLYTICS, OTHER	3
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/ SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	3

CATEGORY	CLASS	SUBMISSION COUNT
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	5
BIPOLAR AGENTS	MOOD STABILIZERS	5
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	11
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	1
BLOOD GLUCOSE REGULATORS	INSULINS	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	5
BLOOD PRODUCTS/MODIFIERS VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	7
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	5
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	4
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	3
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	10
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	9
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	7
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	5
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	2
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	3
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	3
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	5
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	3
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	5
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	2
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	3
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	4
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	2
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	0
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	5
DENTAL AND ORAL AGENTS	NO USP CLASS	6
DERMATOLOGICAL AGENTS	NO USP CLASS	10
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	4
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	2
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	4
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	0
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	1

CATEGORY	CLASS	SUBMISSION COUNT
GASTROINTESTINAL AGENTS	LAXATIVES	1
GASTROINTESTINAL AGENTS	PROTECTANTS	2
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	0
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	3
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	6
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	3
GENITOURINARY AGENTS	PHOSPHATE BINDERS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOIDS/MINERALOCORTICOIDS	17
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	2
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	0
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	3
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	5
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)	NO USP CLASS	2
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	0
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	1
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	4
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	3
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	11
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	5
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	2
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	5
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	3
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	0
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	2
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	6

CATEGORY	CLASS	SUBMISSION COUNT
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	8
OTIC AGENTS	NO USP CLASS	3
RESPIRATORY TRACT AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	5
RESPIRATORY TRACT AGENTS	ANTIHISTAMINES	5
RESPIRATORY TRACT AGENTS	ANTILEUKOTRIENES	1
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)	2
RESPIRATORY TRACT AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	6
RESPIRATORY TRACT AGENTS	MAST CELL STABILIZERS	1
RESPIRATORY TRACT AGENTS	PULMONARY ANTIHYPERTENSIVES	4
RESPIRATORY TRACT AGENTS	RESPIRATORY TRACT AGENTS, OTHER	2
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	3
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	2
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	2
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	4
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	3