HealthPartners Gold MN
For Small Employers Plan
Benefits Chart

NOTICE: THIS DISCLOSURE IS REQUIRED BY MINNESOTA LAW. THIS CONTRACT IS EXPECTED TO RETURN ON AVERAGE 88.3 PERCENT OF YOUR PAYMENT DOLLAR FOR HEALTH CARE. THE LOWEST PERCENTAGE PERMITTED BY STATE LAW FOR THIS CONTRACT IS 82 PERCENT.

Effective Date: The later of the effective date, or most recent anniversary date, of the Master Group Contract and your effective date of coverage under the Master Group Contract.

HealthPartners agrees to cover the services described below. The Benefits Chart describes the level of payment that applies for each of the covered services. To be covered under this section, the medical or dental services or items described below must be medically or dentally necessary.

Coverage for eligible services is subject to the exclusions, limitations, and other conditions of this Benefits Chart and Group Membership Contract.

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

The amount that we pay for covered services is listed below. The member is responsible for the specified dollar amount and/or percentage of charges that we do not pay.

Network Benefits are underwritten by HealthPartners, Inc. Non-Network Benefits are underwritten by HealthPartners Insurance Company.

In HealthPartners Open Access Choice, you have direct access to any Network providers listed in the HealthPartners Open Access Network provider directory.

Coverage may vary depending on whether you select a Network provider or a Non-network provider.

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 does not usually have an agreement with HealthPartners to provide services at a discounted fee. In addition, Non-Network Benefits are restricted to the usual and customary amount under the definition of "Charge". The usual and customary amount can be significantly lower than a Non-Network provider's billed charges. 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. The only exceptions to this requirement are described below in the "Emergency and Urgently Needed Care Services" section. This section describes what benefits are covered at the Network Benefit level regardless of who provides the service.

These definitions apply to the Benefits Chart. They also apply to the Contract.

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

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

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

For the Usual and Customary Charge for covered services delivered by non-network providers, our payment is based on a percentage of the Medicare fee schedule, or a comparable schedule if the service is not on the Medicare fee schedule.

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 out-of-pocket limit.

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

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

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

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

A copayment or coinsurance is due at the time a service is provided, or when billed by the provider. The copayment or coinsurance applicable for a scheduled visit with a network provider will be collected for each visit, late cancellation and failed appointment.

Deductible: The specified dollar amount of charges incurred for covered services, which we do not pay, but a member or a family has to pay first in a calendar year. Our payment for those services or items begins after the deductible is satisfied. For network providers, the amount of the charges that apply to the deductible are based on the network provider's discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule rate for case rate or withhold arrangements. For non-network providers, the amount of charges that apply to the deductible are the lesser of the provider's charges or the usual and customary charge for a service.

This plan has an embedded deductible. The plan begins paying benefits that require cost sharing for the first family member who meets the individual deductible. The family deductible must then be met by one or more of the remaining family members and then the plan pays benefits for all covered family members.

All services are subject to the deductible unless otherwise indicated below in the Benefits Chart.

Formulary: This is a current list, which may be revised from time to time, of formulary prescription drugs, medications, equipment and supplies covered by us as indicated in the Benefits Chart which are covered at the highest benefit level. Some drugs may require prior authorization to be covered as formulary drugs. You may be granted an exception to the formulary that is available to you upon request. These guidelines and procedures include exceptions to the formulary for anti-psychotic prescription drugs prescribed to treat emotional disturbances or mental illness if your health care provider (1) indicates to the dispensing pharmacist, orally or in writing, that the prescription must be dispensed as indicated and (2) certifies in writing to us that the prescribed drug will best treat your condition. Also, you may continue to receive certain non-formulary prescription drugs for diagnosed mental illness or emotional disturbance when our formulary changes or you change health plans for up to one year following the change. We also have written guidelines and procedures for granting formulary exceptions for other drugs that are available to you upon request or on our website.

You or your provider can request an exception to our formulary. If the request is approved, the non-formulary drug you are requesting would be covered. Requests are generally reviewed and responded on the day they are requested. Decisions are made on a case-by-case basis. You or your provider can request an exception using the Prior Authorization/Exception form on our website or by calling Member Services. We review exception requests based on diagnosis, formulary medicines that you have already tried, evidence that the medicine you want to take is effective and medical necessity. If we do not approve your request, you can request an exception review, as described in the Complaints section of the contract.

The formulary, and information on drugs that require authorization, are available by calling Member Services, or log on to your "myHealthPartners" account at www.healthpartners.com.

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

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

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

Out-of-Pocket Limit:

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

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

Non-Network benefits for transplant surgery do not apply to the out-of-pocket limit.

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

Specialty Drug List:

This is a current list, which may be revised from time to time, of prescription drugs, medications, equipment and supplies, which are typically bio-pharmaceuticals. The purpose of a specialty drug list is to facilitate enhanced monitoring of complex therapies used to treat specific conditions. Specialty drugs are covered by us as indicated below. The specialty drug list is available by calling Member Services, or logging on to your "*my*HealthPartners" account at www.healthpartners.com.

Individual Calendar Year Deductible

Network Benefits	Non-Network Benefits
$1,000	$10,000

Family Calendar Year Deductible

Network Benefits	Non-Network Benefits
$3,000	$20,000

Separate deductibles must be satisfied under the Network Benefits and Non-Network Benefits.

This plan has an embedded deductible. The plan begins paying benefits that require cost sharing for the first family member who meets the individual deductible. The family deductible must then be met by one or more of the remaining family members and then the plan pays benefits for all covered family members.

Individual Calendar Year Out-of-Pocket Limit

Network Benefits	Non-Network Benefits
$4,000	$30,000

Family Calendar Year Out-of-Pocket Limit

Network Benefits	Non-Network Benefits
$8,000	$60,000

Separate Out-of-Pocket Limits must be satisfied under the Network Benefits and Non-Network Benefits.

Any reduction in benefits for failure to comply with CareCheck® requirements will not apply toward the Out-of-Pocket Limit.

Non-Network Benefits above the usual and customary charge will not apply toward the individual or family out-of-pocket limit.

BENEFITS CHART

A. AMBULANCE AND MEDICAL TRANSPORTATION

Covered Services:

We cover ambulance and medical transportation for medical emergencies and as shown below.

We also cover medically necessary, non-emergency medical transportation if it meets our medical criteria.

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

Ambulance and medical transportation for medical emergencies (other than non-emergency fixed wing air ambulance transportation)

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	See Network Benefits.

Non-emergency fixed wing air ambulance transportation

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

Not Covered:

- See Services Not Covered in the Group Membership Contract Section III.

B. BEHAVIORAL HEALTH SERVICES

Covered Services:

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

Mental Health Services

We cover services for: mental health diagnoses as described in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM5) (most recent edition) that lead to significant disruption of function in the member's life.

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

BENEFITS CHART

a. Outpatient Services (including intensive outpatient and day treatment): We cover medically necessary outpatient professional mental health services for evaluation, crisis intervention, and treatment of mental health disorders.

A comprehensive diagnostic assessment will be made of each patient as the basis for a determination by a mental health professional, concerning the appropriate treatment and the extent of services required.

Outpatient services we cover for a diagnosed mental health condition include the following:
1) Individual, group, family, and multi-family therapy;
2) Medication management provided by a physician, certified nurse practitioner, or physician's assistant;
3) Psychological testing services for the purposes of determining the differential diagnoses and treatment planning for patients currently receiving behavioral health services;
4) Day treatment and intensive outpatient services in a licensed program;
5) Partial hospitalization services in a licensed hospital or community mental health center; and
6) Psychotherapy and nursing services provided in the home if authorized by us.
7) We cover treatment for gender reassignment that meets medical coverage criteria.

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

First three visits	
Network Benefits The first three mental and chemical health visits, urgent care visits, office visits, convenience clinic visits, telephone visits and e-visits (other than virtuwell) combined in a calendar year are covered at 100%, not subject to the deductible. Physicians services are included; however charges for day treatment services, group visits, office procedures, laboratory, radiology and other ancillary services are not included and will be subject to your deductible and coinsurance.	

Group Therapy

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

b. Inpatient Services, including psychiatric residential treatment for emotionally disabled children: We cover 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.

We cover residential care for the treatment of eating disorders in a licensed facility, as an alternative to inpatient care, when it is medically necessary and your physician obtains authorization from us.

We also cover medically necessary psychiatric residential treatment for emotionally disabled children as diagnosed by a physician. This care must be authorized by us and provided by a hospital or residential treatment center licensed by the local state or Health and Human Services Department. The child must be under 18 years of age and an eligible dependent

according to the terms of this Contract. Services not covered under this benefit include shelter services, correctional services, detention services, transitional services, group residential services, foster care services and wilderness programs.

Network Benefits	Non-Network Benefits
70% of the charges incurred.	50% of the charges incurred.

Chemical Health Services

We cover medically necessary services for assessments by a licensed alcohol and drug counselor and treatment of Substance-Related Disorders as defined in the latest edition of the DSM5.

a. Outpatient Services, including intensive outpatient and day treatment services: We cover medically necessary outpatient professional services for the diagnosis and treatment of chemical dependency. Chemical dependency treatment services must be provided by a program licensed by the local Health and Human Services Department.

Outpatient services we cover for a diagnosed chemical dependency condition include the following:
(1) Individual, group, family, and multi-family therapy provided in an office setting;
(2) We cover opiate replacement therapy including methadone and buprenorphine treatment; and
(3) Day treatment and intensive outpatient services in a licensed program.

Network Benefits	Non-Network Benefits
70% of the charges incurred.	50% of the charges incurred.

First three visits	
Network Benefits The first three mental and chemical health visits, urgent care visits, office visits, convenience clinic visits, telephone visits and e-visits (other than virtuwell) combined in a calendar year are covered at 100%, not subject to the deductible. Physicians services are included; however charges for day treatment services, group visits, office procedures, laboratory, radiology and other ancillary services are not included and will be subject to your deductible and coinsurance.	

Network Benefits	Non-Network Benefits
We cover supervised lodging at a contracted organization for members actively involved in an affiliated licensed chemical dependency day treatment or intensive outpatient program for treatment of alcohol or drug abuse.	We cover supervised lodging at a contracted organization for members actively involved in an affiliated licensed chemical dependency day treatment or intensive outpatient program for treatment of alcohol or drug abuse.

b. Inpatient Services: We cover medically necessary inpatient services in a hospital or primary residential treatment in a licensed chemical health treatment center. Primary residential treatment is an intensive residential treatment program of limited duration, typically 30 days or less.

BENEFITS CHART

We cover services provided in a hospital that is licensed by the local state and accredited by Medicare.

Detoxification Services. We cover detoxification services in a hospital or community detoxification facility if it is licensed by the local Health and Human Services Department.

Network Benefits	Non-Network Benefits
70% of the charges incurred.	50% of the charges incurred.

Not Covered:

- See Services Not Covered in the Group Membership Contract Section III.

C. CHIROPRACTIC SERVICES

Covered Services:

We cover chiropractic services for rehabilitative care, provided to diagnose and treat acute neuromusculo-skeletal conditions.

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

Network Benefits	Non-Network Benefits
70% of the charges incurred.	50% of the charges incurred. Limit of 20 visits per calendar year.

Not Covered:

- Massage therapy for the purpose of comfort or convenience of the member.
- See Services Not Covered in the Group Membership Contract Section III.

D. CLINICAL TRIALS

Covered Services:

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

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

Not Covered:

- The investigative item, device or service itself.

- Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- See Services Not Covered in the Group Membership Contract Section III.

E. DENTAL SERVICES

Covered Services:

We cover services as described below.

Accidental Dental Services

Accidental Dental Services: We cover dentally necessary services to treat and restore damage done to sound, natural, unrestored teeth as a result of an accidental injury. Coverage is for damage caused by external trauma to face and mouth only, not for cracked or broken teeth which result from biting or chewing. We cover restorations, root canals, crowns and replacement of teeth lost that are directly related to the accident in which the member was involved. We cover initial exams, x-rays, and palliative treatment including extractions, and other oral surgical procedures directly related to the accident. Subsequent treatment must be initiated within the contract's time-frame and must be directly related to the accident. We do not cover restoration and replacement of teeth that are not "sound and natural" at the time of the accident.

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

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

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

For all accidental dental services, treatment and/or restoration must be initiated within six months of the date of the injury. Coverage is limited to the initial course of treatment and/or initial restoration. Services must be provided within twenty-four months of the date of injury to be covered.

Medical Referral Dental Services

a. Medically Necessary Outpatient Dental Services: We cover medically necessary outpatient dental services. Coverage is limited to dental services required for treatment of an underlying medical condition, e.g., removal of teeth to complete radiation treatment for cancer of the jaw, cysts and lesions.

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

b. Medically Necessary Hospitalization and Anesthesia for Dental Care: We cover medically necessary hospitalization for dental care. This is limited to charges incurred by a member who: (1) is a child under age 5; (2) is severely disabled; (3) has a medical condition, and requires hospitalization or general anesthesia for dental care treatment; or (4) is a child between age 5 and 12 and care in dental offices has been attempted unsuccessfully and usual methods of behavior modification have not been successful, or when extensive amounts of restorative care, exceeding 4 appointments, are required. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist professional fees are not covered.

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

c. Medical Complications of Dental Care: We cover medical complications of dental care. Treatment must be medically necessary care and related to medical complications of non-covered dental care, including complications of the head, neck, or substructures.

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

Oral Surgery: We cover oral surgery. Coverage is limited to treatment of medical conditions requiring oral surgery, such as treatment of oral neoplasm, non-dental cysts, fracture of the jaws, trauma of the mouth and jaws.

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

Treatment of Cleft Lip and Cleft Palate: We cover treatment of cleft lip and cleft palate of a dependent child to age 26, including orthodontic treatment and oral surgery directly related to the cleft. Benefits are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. Dental services which are not required for the treatment of cleft lip or cleft palate are not covered. If a dependent child covered under this Contract is also covered under a dental plan which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same copayment, conditions and limitations as durable medical equipment.

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD): We cover surgical and non-surgical treatment of temporomandibular disorder (TMD) and craniomandibular disorder (CMD), which is medically necessary care. Dental services which are not required to directly treat TMD or CMD are not covered.

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

Not Covered:

- Dental treatment, procedures or services not listed in this Benefits Chart.

- Accident related dental services if treatment is (1) provided to teeth which are not sound and natural, (2) to teeth which have been restored, (3) initiated beyond six months from the date of the injury, (4) received beyond the initial treatment or restoration or (5) received beyond twenty-four months from the date of injury.
- Oral surgery to remove wisdom teeth.
- Orthognathic treatment or procedures and all related services, unless it is required to treat TMD or CMD and it meets our medical coverage criteria.
- See Services Not Covered in the Group Membership Contract Section III.

F. DIAGNOSTIC IMAGING SERVICES

Covered Services:

We cover diagnostic imaging, when ordered by a provider and provided in a clinic or outpatient hospital facility.

For Network Benefits, non-emergent, scheduled outpatient Magnetic Resonance Imaging (MRI) and computing Tomography (CT) must be provided at a designated facility. Your physician and facility will obtain or verify authorization for these services with HealthPartners, as needed.

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

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

Network Benefits	Non-Network Benefits
70% of the charges incurred.	50% of the charges incurred.

(b) All other outpatient diagnostic imaging services for illness or injury

Services for illness or injury

Network Benefits	Non-Network Benefits
70% of the charges incurred.	50% of the charges incurred.

Preventive services (MRI/CT procedures are not considered preventive)

Network Benefits	Non-Network Benefits
Diagnostic imaging for preventive services is covered at the benefit level shown in the Preventive Services section.	

Not Covered:

- See Services Not Covered in the Group Membership Contract Section III.

G. DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES

Covered Services:

We cover equipment and services, as described below.

BENEFITS CHART

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

External hearing aids (including osseointegrated or bone anchored) for members age 18 or younger who have hearing loss that is not correctable by other covered procedures. Coverage is limited to one hearing aid for each ear every three years.

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

Wigs for hair loss resulting from alopecia areata are limited to one per calendar year. No more than a 93-day supply of diabetic supplies are covered and dispensed at a time. Diabetic supplies purchased at a network pharmacy are not subject to the deductible.

Special dietary treatment for Phenylketonuria (PKU) if it meets our medical coverage criteria

Network Benefits	**Non-Network Benefits**
70% of the charges incurred. Deductible does not apply.	50% of the charges incurred.

Oral amino acid based elemental formula if it meets our medical coverage criteria

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

Limitations:

Coverage of durable medical equipment is limited by the following:

- Payment will not exceed the cost of an alternate piece of equipment or service that is effective and medically necessary.
- For prosthetic benefits, other than hair prostheses (i.e., wigs) for hair loss resulting from alopecia areata and oral appliances for cleft lip and cleft palate, payment will not exceed the cost of an alternate piece of equipment or service that is effective, medically necessary and enables members to conduct standard activities of daily living.
- We reserve the right to determine if an item will be approved for rental vs. purchase.
- Diabetic supplies and equipment are limited to certain models and brands.
- Durable medical equipment and supplies must be obtained from or repaired by approved vendors.
- Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. Our coverage policy for diabetic supplies includes information on our required models and brands. These medical policies (medical coverage criteria) are available by calling Member Services, or logging on to your "*my*HealthPartners" account at www.healthpartners.com.

BENEFITS CHART

Not Covered:

Items which are not eligible for coverage include, but are not limited to:

- Replacement or repair of any covered items, if the items are (i) damaged or destroyed by misuse, abuse or carelessness, (ii) lost; or (iii) stolen.
- Duplicate or similar items.
- Labor and related charges for repair of any covered items which are more than the cost of replacement by an approved vendor.
- Sales tax, mailing, delivery charges, service call charges.
- Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience or recreation.
- Communication aids or devices: equipment to create, replace or augment communication abilities including, but not limited to, hearing aids (implantable and external, including osseointegrated or bone anchored) and fitting of hearing aids except as required by law, speech processors, receivers, communication boards, or computer or electronic assisted communication, except as specifically described in this Contract. This exclusion does not apply to cochlear implants, which are covered as described in the medical coverage criteria. Medical coverage criteria are available by calling Member Services, or logging on to your "*my*HealthPartners" account at www.healthpartners.com.
- Household equipment which primarily has customary uses other than medical, such as, but not limited to, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds.
- Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas.
- Modifications to the structure of the home including, but not limited to, its wiring, plumbing or charges for installation of equipment.
- Vehicle, car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier.
- Rental equipment while owned equipment is being repaired by non-contracted vendors, beyond one month rental of medically necessary equipment.
- Other equipment and supplies, including but not limited to assistive devices, that we determine are not eligible for coverage.
- See Services Not Covered in the Group Membership Contract Section III.

H. EMERGENCY AND URGENTLY NEEDED CARE SERVICES

Covered Services:

We cover services for emergency care and urgently needed care if the services are otherwise eligible for coverage under this Contract.

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

Urgently Needed care at clinics

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

BENEFITS CHART

First three visits	
Network Benefits The first three mental and chemical health visits, urgent care visits, office visits, convenience clinic visits, telephone visits and e-visits (other than virtuwell) combined in a calendar year are covered at 100%, not subject to the deductible. Physicians services are included; however charges for day treatment services, group visits, office procedures, laboratory, radiology and other ancillary services are not included and will be subject to your deductible and coinsurance.	

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

When reviewing claims for coverage of emergency services, our medical director will take into consideration a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next working day or next available clinic appointment. Emergency care also includes an immediate response service available on a 24-hour, seven-day-a-week basis for each child, or person, having a psychiatric crisis, a mental health crisis, or a mental health emergency.

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

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	See Network Benefits.

b. Inpatient emergency care in a hospital

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	See Network Benefits.

Not Covered:

- See Services Not Covered in the Group Membership Contract Section III.

I. HEALTH EDUCATION

Covered Services:

We cover education for preventive services and education for the management of chronic health problems (such as diabetes).

BENEFITS CHART

Provider office visit/session in connection with preventive services

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.

Provider office visit/session in connection with the management of a chronic health problem (such as diabetes)

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.

Not Covered:

- See Services Not Covered in the Group Membership Contract Section III.

J. HOME HEALTH SERVICES

Covered Services:

We cover skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy and other therapeutic services, non-routine prenatal and postnatal services, routine postnatal well child visits (as described in the Medical Coverage Criteria), phototherapy services for newborns, home health aide services and other eligible home health services when provided in your home, if you are homebound (i.e., unable to leave home without considerable effort due to a medical condition. Lack of transportation does not constitute homebound status). For phototherapy services for newborns and high risk pre-natal services, supplies and equipment are included.

We cover total parenteral nutrition/intravenous ("TPN/IV") therapy, equipment, supplies and drugs in connection with IV therapy. IV line care kits are covered under Durable Medical Equipment.

You do not need to be homebound to receive total parenteral nutrition/intravenous ("TPN/IV") therapy.

We cover palliative care benefits. Palliative care includes symptom management, education and establishing goals of care. We waive the requirement that you be homebound for a limited number of home visits for palliative care (as shown in the Benefits Chart), if you have a life-threatening, non-curable condition which has a prognosis of survival of two years or less. Additional palliative care visits are eligible under the home health services benefit if you are homebound and meet all other requirements defined in this section.

Home health services are eligible and covered only when they are:
(1) medically necessary; and
(2) provided as rehabilitative care, terminal care or maternity care; and
(3) ordered by a physician, and included in the written home care plan.

Limitations:

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

BENEFITS CHART

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

Network Benefits	Non-Network Benefits
70% of the charges incurred.	50% of the charges incurred.

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

Network Benefits	Non-Network Benefits
70% of the charges incurred.	50% of the charges incurred.

Each 24-hour visit (or shifts of up to 24-hour visits) equals one visit and counts toward the Maximum visits for all other services shown below. Any visit that lasts less than 24 hours, regardless of the length of the visit, will count as one visit toward the Maximum visits for all other services shown below. All visits must be medically necessary and benefit eligible.

Routine postnatal well child visits

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.

Maximum visits for palliative 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.

Maximum visits for all other services

Network Benefits	Non-Network Benefits
120 visits per calendar year.	60 visits per calendar year.

Each visit provided under the Network Benefits and Non-Network Benefits counts toward the maximums shown under all Maximum visits sections. The routine postnatal well child visit does not count toward the visit limit.

Not Covered:

- Financial or legal counseling services.
- Housekeeping or meal services in your home.
- Private duty nursing services. This exclusion does not apply if covered person is also covered under Medical Assistance under 256B.0625, subdivision 7, with the exception of section 256B.0654 subdivision 4.
- Services provided by a family member or enrollee, or a resident in the enrollee's home.
- Vocational rehabilitation and recreational or educational therapy. Recreation therapy is therapy provided solely for the purpose of recreation, including but not limited to: (a) requests for physical therapy or occupational therapy to improve athletic ability, and (b) braces or guards to prevent sports injuries.
- See Services Not Covered in the Group Membership Contract Section III.

K. HOME HOSPICE SERVICES

Applicable Definitions:

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

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

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

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

Covered Services:

Home Hospice Program. We cover the services described below if you are terminally ill and accepted as a home hospice program participant. You must meet the eligibility requirements of the program, and elect to receive services through the home hospice program. The services will be provided in your home, with inpatient care available when medically necessary as described below. If you elect to receive hospice services, you do so in lieu of curative treatment for your terminal illness for the period you are enrolled in the home hospice program.

a. Eligibility: In order to be eligible to be enrolled in the home hospice program, you must: (1) be a terminally ill patient (prognosis of six months or less); (2) have chosen a palliative treatment focus (i.e., emphasizing comfort and supportive services rather than treatment attempting to cure the disease or condition); and (3) continue to meet the terminally ill prognosis as reviewed by our medical director or his or her designee over the course of care. You may withdraw from the home hospice program at any time.

b. Eligible Services: Hospice services include the following services provided by Medicare-certified providers, if provided in accordance with an approved hospice treatment plan.
   (1) Home Health Services:
      (a) Part-time care provided in your home by an interdisciplinary hospice team (which may include a physician, nurse, social worker, and spiritual counselor) and medically necessary home health services are covered.
      (b) One or more periods of continuous care in your home or in a setting which provides day care for pain or symptom management, when medically necessary, will be covered.
   (2) Inpatient Services: We cover medically necessary inpatient services.
   (3) Other Services:
      (a) Respite care is covered for care in your home or in an appropriate facility, to give your primary caregivers (i.e., family members or friends) rest and/or relief when necessary in order to maintain a terminally ill patient at home.
      (b) Medically necessary medications for pain and symptom management.
      (c) Semi-electric hospital beds and other durable medical equipment are covered.
      (d) Emergency and non-emergency care is covered.

BENEFITS CHART

Network Benefits	Non-Network Benefits
70% of the charges incurred.	50% of the charges incurred.

Respite care is limited to 5 days per episode, and respite care and continuous care combined are limited to 30 days.

Not Covered:

- Financial or legal counseling services; or
- Housekeeping or meal services in your home; or
- Custodial or maintenance care related to hospice services, whether provided in the home or in a nursing home; or
- Any service not specifically described as covered services under this home hospice services benefits; or
- Any services provided by members of your family or residents in your home.
- See Services Not Covered in the Group Membership Contract Section III.

L. HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Covered Services:

We cover services as described below.

Medical or Surgical Hospital Services

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

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

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

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

We cover, following a vaginal delivery, a minimum of 48 hours of inpatient care for the mother and newborn child. We cover, following a caesarean section delivery, a minimum of 96 hours of inpatient care for the mother and newborn child. If the duration of inpatient care is less than these minimums, we also cover a minimum of one home visit by a registered nurse for post-delivery care, within 4 days of discharge of the mother and newborn child. Services provided by the registered nurse include, but are not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. We shall not provide any compensation or other non-medical remuneration to encourage a mother and newborn to leave inpatient care before the duration minimums specified.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending

provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

Each member's admission or confinement, including that of a newborn child, is separate and distinct from the admission or confinement of any other member.

Outpatient Hospital, Ambulatory Care or Surgical Facility Services: We cover the following medical and surgical services, for diagnosis or treatment of illness or injury on an outpatient basis. These services must be authorized by a physician.

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

For Network Benefits, non-emergent, scheduled outpatient Magnetic Resonance Imaging (MRI) and computing Tomography (CT) must be provided at a designated facility. Your physician and facility will obtain or verify authorization for these services with HealthPartners, as needed.

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

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

Skilled Nursing Facility Care

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

Network Benefits	**Non-Network Benefits**
70% of the charges incurred. Limited to 120 day maximum per period of confinement.	50% of the charges incurred. Limited to 120 day maximum per period of confinement.

Each day of services provided under the Network Benefits and Non-Network Benefits combined, counts toward the maximums shown above.

Not Covered:

- Services for items for personal convenience, such as television rental, are not covered.
- See Services Not Covered in the Group Membership Contract Section III.

M. INFERTILITY SERVICES

Covered Services:

We cover the diagnosis of infertility. These services include diagnostic procedures and tests provided in connection with an infertility evaluation, office visits and consultations to diagnose infertility.

Network Benefits	Non-Network Benefits
70% of the charges incurred.	50% of the charges incurred.

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

Not Covered:

- Reversal of sterilization, assisted reproduction, including, but not limited to gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT) intracytoplasmic sperm injection (ICSI), and/or in-vitro fertilization (IVF), and all charges associated with such procedures; treatment of infertility, including but not limited to, office visits, laboratory and diagnostic imaging services; and sperm, ova or embryo acquisition, retrieval or storage; however, we cover office visits and consultations to diagnose infertility.
- Services related to the establishment of surrogate pregnancy and fees for a surrogate are not covered.
- All drugs used for the treatment of infertility.
- See Services Not Covered in the Group Membership Contract Section III.

N. LABORATORY SERVICES

Covered Services:

We cover laboratory tests, when ordered by a provider and provided in a clinic or outpatient hospital facility.

To see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services in this Benefits Chart.

Services for illness or injury

Network Benefits	Non-Network Benefits
70% of the charges incurred.	50% of the charges incurred.

BENEFITS CHART

Preventive Services

Network Benefits	Non-Network Benefits
Laboratory for preventive services is covered at the benefit level shown in the Preventive Services section in this Benefit Chart.	

Not Covered:

- See Services Not Covered in the Group Membership Contract Section III.

O. LYME DISEASE SERVICES

Covered Services:

We cover services for the treatment of Lyme disease.

Network Benefits	Non-Network Benefits
Coverage level is same as corresponding Network benefit, depending on type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Non-Network benefit, depending on type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

Not Covered:

- See Services Not Covered in the Group Membership Contract Section III.

P. MASTECTOMY RECONSTRUCTION BENEFIT

Covered Services:

We cover reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Network Benefits	Non-Network Benefits
Coverage level is same as corresponding Network benefit, depending on type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Non-Network benefit, depending on type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

Not Covered:

- See Services Not Covered in the Group Membership Contract Section III.

BENEFITS CHART

Q. OFFICE VISITS FOR ILLNESS OR INJURY

Covered Services:

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

We cover diagnosis and treatment of illness or injury to the eyes. Where contact or eyeglass lenses are prescribed as medically necessary for the post-operative treatment of cataracts or for the treatment of aphakia, or keratoconus, we cover the initial evaluation, lenses and fitting. Members must pay for lens replacement beyond the initial pair.

We also provide coverage for the initial physical evaluation of a child if it is ordered by a Minnesota juvenile court.

Office Visits

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

Convenience clinics

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

Scheduled telephone visits

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

E-visits

Access To Online Care through virtuwell at www.virtuwell.com

Network Benefits	**Non-Network Benefits**
100% of the charges incurred. Deductible does not apply.	No Coverage.

All other E-visits

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

BENEFITS CHART

First three visits	
Network Benefits The first three mental and chemical health visits, urgent care visits, office visits, convenience clinic visits, telephone visits and e-visits (other than virtuwell) combined in a calendar year are covered at 100%, not subject to the deductible. Then services will be covered at the coinsurance and deductible indicated for mental and chemical health visits, urgent care visits, office visits, convenience clinic visits, telephone visits and e-visits (other than virtuwell). Physicians services are included; however charges for day treatment services, group visits, office procedures, laboratory, radiology and other ancillary services are not included and will be subject to your deductible and coinsurance.	

Injections administered in a physician's office, other than immunizations

Allergy injections

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

All other injections

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred.

Not Covered:

- Court ordered treatment, except as described in this benefits chart section B., subsection "Mental Health Services" and section Q. "Office Visits for Illness or Injury" or as otherwise required by law.
- See Services Not Covered in the Group Membership Contract Section III.

BENEFITS CHART

R. PEDIATRIC EYEWEAR

Covered Services:

We cover pediatric eyewear for children, subject to our medical coverage criteria. This provision will continue until the end of the month in which the child turns age 19. These medical policies (medical coverage criteria) are available by calling Member Services, or logging on to your account at www.healthpartners.com.

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	No Coverage.

Limited to one pair of eyeglasses (lenses and frames) or one pair of contact lenses per benefit year.

Not Covered:

- Replacement of eyeglasses or contact lenses due to loss or theft.
- See Services Not Covered in the Group Membership Contract Section III.

S. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY

Covered Services:

We cover the following physical therapy, occupational therapy and speech therapy services:
(1) rehabilitative care to correct the effects of illness or injury;
(2) habilitative care rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development.

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

We cover services provided in a clinic. We also cover physical therapy provided in an outpatient hospital facility. To see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services.

Rehabilitative Care

Network Benefits	**Non-Network Benefits**
70% of the charges incurred.	50% of the charges incurred. Physical and Occupational Therapy combined are limited to 20 visits per calendar year. Speech Therapy is limited to 20 visits per calendar year.

BENEFITS CHART

Habilitative Care

Network Benefits	Non-Network Benefits
70% of the charges incurred.	50% of the charges incurred. Physical, Occupational and Speech Therapy combined are limited to 20 visits per calendar year.

Not Covered:

- Massage therapy for the purpose of comfort or convenience of the member.
- See Services Not Covered in the Group Membership Contract Section III.

T. PORT WINE STAIN REMOVAL SERVICES

Covered Services:

We cover port wine removal services.

Network Benefits	Non-Network Benefits
Coverage level is same as corresponding Network benefit, depending on type of service provided such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Non-Network benefit, depending on type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

Not Covered:

- See Services Not Covered in the Group Membership Contract Section III.

U. PRESCRIPTION DRUG SERVICES

Covered Services:

We cover prescription drugs and medications, which can be self-administered or are administered in a physician's office. We cover off-label use of formulary drugs to treat cancer if the drug is recognized for the treatment of cancer in any authoritative compendia used by the Medicare program.

For Network Benefits, drugs and medications must be obtained at a Network Pharmacy.

Outpatient drugs (other than tobacco cessation, contraceptive drugs, specialty and growth deficiency drugs)

Network Benefits	Non-Network Benefits
100% of the charges incurred, subject to a member copayment of $15 for generic formulary drugs and $50 for brand formulary drugs. Non-formulary drugs are covered at 100% of the charges incurred, subject to a member copayment of $100. Deductible does not apply.	50% of the charges incurred.

Drugs for the treatment of sexual dysfunction are not covered. Non-sedating oral antihistamines are not covered if there are over-the-counter therapeutic alternatives.

Tobacco cessation drugs are covered for all FDA – approved tobacco cessation drugs for a minimum of 90 days

Network Benefits	**Non-Network Benefits**
100% of the charges incurred for formulary drugs. Deductible does not apply.	See Non-Network Outpatient Drugs benefit.

Mail order drugs

Network Benefits	**Non-Network Benefits**
You may also get outpatient prescription drugs which can be self-administered through HealthPartners mail order service. Outpatient drugs ordered through this service are covered at the benefit percent shown in Outpatient Drugs above, subject to two copayments for each 93-day supply, or portion thereof. New prescriptions to treat certain chronic conditions and trial drugs will be limited to quantity limits described at the end of this section. You will have to pay one copayment for your initial 31-day supply. Specialty Drugs are not available through the mail order service.	See HealthPartners Mail Order Drugs benefit.

Specialty Drugs which are self-administered

Network Benefits	**Non-Network Benefits**
80% of the charges incurred, up to a maximum copayment of $200. Deductible does not apply.	50% of the charges incurred.

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

Drugs for the treatment of growth deficiency

Network Benefits	**Non-Network Benefits**
70% of the charges incurred. Deductible does not apply.	50% of the charges incurred.

BENEFITS CHART

For Network Benefits, growth deficiency drugs are limited to drugs on the specialty drug list and must be obtained from a designated vendor.

Contraceptive drugs

Network Benefits	**Non-Network Benefits**
100% of the charges incurred for formulary drugs. Deductible does not apply. If a physician requests that a non-formulary contraceptive drug be dispensed as written and we determine the contraceptive drug is medically necessary, the drug will be covered at 100%, not subject to the deductible.	50% of the charges incurred.

Limitations:

- *Unless otherwise specified in the Prescription Drug Services section, you may receive up to a 31-day supply per prescription. Certain drugs may require prior authorization as indicated on the formulary. HealthPartners may require prior authorization for the drug and also the site where the drug will be provided. Certain drugs are subject to our utilization review process and quantity limits, as indicated on our formulary. New prescriptions to treat certain chronic conditions are limited to a 31-day supply. Certain non-formulary drugs require prior authorization. In addition, certain drugs may be subject to any quantity limits applied as part of our trial program. A 93-day supply will be covered and dispensed only at pharmacies that participate in our extended day supply program. No more than a 31-day supply of Specialty Drugs will be covered and dispensed at a time.*
- *If a member requests a brand drug when there is a generic equivalent, the brand drug will be covered up to the charge that would apply to the generic drug, minus any required copayment. If a physician requests that a brand drug be dispensed as written, the drug will be paid at the non-formulary benefit.*
- *The member copayment for a drug will not exceed the cost of the drug.*
- *If a member copayment is required, you must pay one member copayment for each 31-day supply, or portion thereof, except for Mail Order Drugs, as described in the mail order drugs benefit above.*

Not Covered:

- Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
- Nonprescription (over the counter) drugs or medications, unless listed on the formulary and prescribed by a physician or legally authorized health care provider under applicable state law, including, but not limited to, vitamins, supplements, homeopathic remedies, and non-FDA approved drugs. We cover off-label use of drugs to treat cancer as specified in the "Prescription Drug Services" section of this Contract. This exclusion does not include over-the-counter contraceptives for women as allowed under the Affordable Care Act when the member obtains a prescription for the item. In addition, if the member obtains a prescription, this exclusion does not include aspirin to prevent cardiovascular disease for men and women of certain ages; folic acid supplements for women who may become pregnant; fluoride chemoprevention supplements for children without fluoride in their water source; and iron supplements for children ages 6-12 who are at risk of anemia.
- All drugs for the treatment of infertility.
- Non-sedating oral antihistamines for which there are over-the-counter therapeutic alternatives.
- See Services Not Covered in the Group Membership Contract Section III.
- Medical cannabis.

BENEFITS CHART

V. PREVENTIVE SERVICES

Covered Services:

Routine preventive services will be as defined by federal and state law. Covered services are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. These medical policies (medical coverage criteria) are available by calling Member Services, or logging on to your "*my*HealthPartners" account at www.healthpartners.com.

1. **Routine health exams and periodic health assessments. A physician or health care provider will counsel you as to how often health assessments are needed based on age, sex and health status. This includes at least three counseling sessions for tobacco cessation.**

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.

2. **Child health supervision services, including pediatric preventive services such as fluoride chemoprevention for children without fluoride in their water source, routine immunizations, developmental assessments and laboratory services appropriate to the age of the child from birth to 72 months, and appropriate immunizations until the end of the month in which the child turns 19.**

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	See Network Benefits.

3. **Routine prenatal care and exams to include visit-specific screening tests, education and counseling.**

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	See Network Benefits.

4. **Routine postnatal care and exams to include health exams, assessments, education and counseling relating to the period immediately after childbirth**

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.

5. **Routine screening procedures for cancer**

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.

BENEFITS CHART

6. Routine eye and hearing exams

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.

7. Professional voluntary family planning services

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	See Network Benefits.

8. Adult immunization

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.

9. Women's preventive services, including mammograms; screenings for cervical cancer; breast pumps; human papillomavirus (HPV) testing; counseling for sexually transmitted infections; counseling and screening for human immunodeficiency virus (HIV); and all FDA approved contraceptive methods, sterilization procedures, education and counseling. We also provide genetic screening for BRCA if someone in your family has the gene or you have a previous diagnosis of cancer.

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.

10. Obesity screening and management. We cover obesity screening and counseling for all ages during a routine preventive care exam. If you are an adult age 18 or older and have a body mass index of 30 or more, we also cover intensive obesity management to help you lose weight. Your primary care doctor can coordinate these services.

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	50% of the charges incurred.

Not Covered:

- See Services Not Covered in the Group Membership Contract Section III.

BENEFITS CHART

W. SPECIFIED NON-NETWORK SERVICES

Covered Services:

We cover the following services when you elect to receive them from a non-network provider, at the same level of coverage we provide when you elect to receive the services from a network provider:

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

Network Benefits	Non-Network Benefits
Coverage level is same as corresponding HealthPartners benefit, depending on type of service provided, such as Office Visits for Illness or Injury.	See Network Benefits for the services covered.

Not Covered:

- See Services Not Covered in the Group Membership Contract Section III.

X. TRANSPLANT SERVICES

Applicable Definitions:

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

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

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

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

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

Designated Transplant Center. This is any health care provider, group or association of health care providers designated by us to provide services, supplies or drugs for specified transplants for our members.

Transplant Services. This is transplantation (including transplants) of the human organs or tissue listed below, including all related post-surgical treatment and drugs and multiple transplants for a related cause. Transplant services do not include other organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, except surgical implantation of an FDA approved Ventricular Assist Device (VAD) or total artificial heart, functioning as a temporary bridge to heart transplantation.

BENEFITS CHART

Covered Services:

We cover eligible transplant services (as defined above) while you are covered under this Contract. Transplants that will be considered for coverage are limited to the following:

1. Kidney transplants for end-stage disease.
2. Cornea transplants for end-stage disease.
3. Heart transplants for end-stage disease.
4. Lung transplants or heart/lung transplants for: (1) primary pulmonary hypertension; (2) Eisenmenger's syndrome; (3) end-stage pulmonary fibrosis; (4) alpha 1 antitrypsin disease; (5) cystic fibrosis; and (6) emphysema.
5. Liver transplants for: (1) biliary atresia in children; (2) primary biliary cirrhosis; (3) post-acute viral infection (including hepatitis A, hepatitis B antigen e negative and hepatitis C) causing acute atrophy or post-necrotic cirrhosis; (4) primary sclerosing cholangitis; (5) alcoholic cirrhosis; and (6) hepatocellular carcinoma.
6. Allogeneic bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for: (1) acute myelogenous leukemia; (2) acute lymphocytic leukemia; (3) chronic myelogenous leukemia; (4) severe combined immunodeficiency disease; (5) Wiskott-Aldrich syndrome; (6) aplastic anemia; (7) sickle cell anemia; (8) non-relapsed or relapsed non-Hodgkin's lymphoma; (9) multiple myeloma; and (10) testicular cancer.
7. Autologous bone marrow transplants or peripheral stem cell support associated with high-dose chemotherapy for: (1) acute leukemias; (2) non-Hodgkin's lymphoma; (3) Hodgkin's disease; (4) Burkitt's lymphoma; (5) neuroblastoma; (6) multiple myeloma; (7) chronic myelogenous leukemia; and (8) non-relapsed non-Hodgkin's lymphoma.
8. Pancreas transplants for simultaneous pancreas-kidney transplants for diabetes, pancreas after kidney, living related segmental simultaneous pancreas kidney transplantation and pancreas transplant alone.

For Network Benefits, charges for transplant services must be incurred at a designated transplant center.

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

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

The list of eligible transplant services and coverage determinations are based on established medical policies, which are subject to periodic review and modifications by the medical director

Network Benefits	**Non-Network Benefits**
See Network Inpatient Hospital Services Benefit.	See Non-Network Inpatient Hospital Services Benefit.

Not Covered:

- We consider the following transplants to be investigative and do not cover them: surgical implantation of mechanical devices functioning as a permanent sustitute for human organ, non-human organ implants and/or transplants and other transplants not specifically listed in the Contract.
- See Services Not Covered in the Group Membership Contract Section III.

Y. ADDITIONAL SERVICES COVERED UNDER THE PLAN

Covered Services:

We cover the following additional program:

Medication Therapy Disease Management Program. 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.

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

Network Benefits	**Non-Network Benefits**
100% of the charges incurred. Deductible does not apply.	No Coverage.

Not Covered:

- See Services Not Covered in the Group Membership Contract Section III.

Z. TELEMEDICINE SERVICES

Covered Services:

We cover telemedicine for services covered under this Contract, subject to our medical criteria.

Network Benefits	**Non-Network Benefits**
Coverage level is same as corresponding Network Benefits, depending upon type of service provided, such as Office Visits for Illness or Injury.	See Network Benefits.

Not Covered:

- See Services Not Covered in the Group Membership Contract Section III.