# HealthPartners Insurance Company
# Platinum
# Wisconsin Small Employer Plan
# Benefits Chart

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

**HealthPartners Insurance Company agrees to cover the services described in this Benefits Chart. 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 the Group Certificate.**

**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.**

**Benefits are underwritten by HealthPartners Insurance Company.**

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

**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.**

**This plan is subject to plan and benefit changes required to maintain compliance with federal and state law. This includes, but is not limited to, benefit changes required to maintain a certain actuarial value or metal level.**

**This plan does include pediatric dental services as required under the federal Patient Protection and Affordable Care Act, see attachment for benefits.**

**These definitions apply to the Benefits Chart. They also apply to the Group Certificate.**

**Biosimilar Drug:** 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. Some brand drugs may be covered at the generic drug benefit level if this is indicated on the formulary.

**Charge:** For covered services provided by a network provider, our payment is based on the negotiated provider fee, minus any applicable deductible, copayment or coinsurance.

For covered services provided by a non-network provider, 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, minus any deductible, copayment or coinsurance.

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 your 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 you must pay, each time you receive 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 the Group Certificate.

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 network charge 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 HealthPartners 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 an enrollee 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. This means once an you meet the individual deductible, we begin paying benefits. If two or more members of the family meet the family deductible, we begin paying benefits for all covered members of the family, regardless of whether each person has met the individual deductible. However, you may not contribute more than the individual deductible towards the family deductible.

All services are subject to the deductible unless otherwise indicated in this 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 on the Formulary may require prior authorization to be covered as formulary drugs. We also have written guidelines and procedures for granting an exception to the Formulary that is available to you upon request. The Formulary, and information on drugs that require prior authorization, are available by calling Member Services, or logging on to your "*my*HealthPartners" 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 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 experimental or otherwise excluded under the Group Certificate.

**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 premium payments.

**Out-of-Pocket Limit:**

You pay the copayment/coinsurance and deductibles for covered services, to the individual or family Out-of-Pocket Limit. Thereafter we cover 100% of the 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.

**Virtuwell**:

Virtuwell is an online service that you may use to receive a diagnosis and treatment for certain routine conditions, such as a cold and flu, ear pain and sinus infections. You may access the virtuwell website at www.virtuwell.com.

**Individual Calendar Year Deductible**

| Network Benefits | Non-Network Benefits |
|---|---|
| None. | $10,000 |

**Family Calendar Year Deductible**

| Network Benefits | Non-Network Benefits |
|---|---|
| None. | $20,000 |

**Individual Calendar Year Out-of-Pocket Limit**

| Network Benefits | Non-Network Benefits |
|---|---|
| $3,000 | $30,000 |

**Family Calendar Year Out-of-Pocket Limit**

| Network Benefits | Non-Network Benefits |
|---|---|
| $6,000 | $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 do not apply to the individual or family Out-of-Pocket Limit.*

*Non-Network Benefits for transplant surgery do not apply to the Out-of-Pocket Limit.*

## Benefits Chart

**Notice: Some benefits listed in this Benefits Chart require precertification. See section I. K. "CareCheck®" of your Certificate for details.**

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

**Ambulance and Medical Transportation (other than non-emergency fixed wing air ambulance transportation)**

| Network Benefits | Non-Network Benefits |
|---|---|
| 95% of the charges incurred. | See Network Benefits. |

**Non-Emergency Fixed Wing Air Ambulance Transportation**

| Network Benefits | Non-Network Benefits |
|---|---|
| 95% of the charges incurred. | 50% of the charges incurred. |

**Not Covered:**

- See Services Not Covered in the Group Certificate Section III.

### B. AUTISM TREATMENT

**Covered Services:**

**Your network provider will coordinate the prior authorization process for any autism treatment services. You may call Member Services at 952-883-5000 or toll-free at 1-800-883-2177 if you have any questions or concerns regarding authorization of your treatment.**

**Please call Member Services at 952-883-5000 or toll-free at 1-800-883-2177 to receive authorization for autism treatment services from a non-network provider.**

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

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

## Benefits Chart

**Intensive-Level Services** *for children diagnosed with autism spectrum disorders. Intensive-level services must begin on or after two years of age and end before nine years of age.*

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred, subject to a copayment of $25 per visit.<br><br>Limited to 330 visits per calendar year. | 50% of the charges incurred.<br><br>Limited to 330 visits per calendar year. |

*The maximum number of visits is combined for the Network Benefits and Non-Network Benefits.*

**Intensive-Level Services Lifetime Maximum**

| Network Benefits | Non-Network Benefits |
|---|---|
| 4 years under this Plan or any other plan. | 4 years under this Plan or any other plan. |

*The Lifetime Maximum is combined for the Network Benefits and Non-Network Benefits.*

**Nonintensive-Level Services** *for Insureds diagnosed with autism spectrum disorders*

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred, subject to a copayment of $25 per visit.<br><br>Limited to 165 visits per calendar year. | 50% of the charges incurred.<br><br>Limited to 165 visits per calendar year. |

*The maximum number of visits is combined for the Network Benefits and Non-Network Benefits.*

**Not Covered:**

- See Services Not Covered in the Group Certificate Section III.

### C. 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 logging on to your "*my*HealthPartners" account at www.healthpartners.com.

**Transitional Treatment Services.** These are services for the treatment of nervous or mental disorders, alcoholism or other drug abuse problems which are provided to an Insured in a less restrictive manner than are inpatient hospital services but in a more intensive manner than are outpatient services. Transitional treatment services are services offered by a provider, and certified by the Wisconsin Department of Health and Family Services for each of the following (except item 6):

1) Mental health services for covered adults in a day treatment program.
2) Mental health services for covered children in a day hospital treatment program.
3) Services for persons with chronic mental illness provided through a community support program.
4) Residential treatment programs for alcohol and/or drug dependent covered persons.

5) Alcohol and Other Drug Abuse (AODA) services in, a day treatment program.
6) Intensive outpatient programs for the treatment of psychoactive substance use disorders provided in accordance with the patient placement criteria of the American society of addictive medicine.
7) Services for persons who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided.

**Mental Health Services**

We cover services for mental health diagnoses as described in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM 5) (most recent edition) that lead to significant disruption of function in your life.

We provide coverage for mental health treatment ordered by a Wisconsin court under a valid court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. 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.

a. **Outpatient Services:** 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) Partial hospitalization services in a licensed hospital or community mental health center.
5) Psychotherapy and nursing services provided in the home if authorized by us.
6) Treatment of gender dysphoria that meets medical coverage criteria.

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| 100% of the charges incurred, subject to a copayment of $25 per visit.<br><br>For family therapy, only one copayment will be charged, regardless of the number of Insureds primarily involved in the therapy. | 50% of the charges incurred. |

**Group Therapy**

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| 100% of the charges incurred, subject to a copayment of $12.50 per visit. | 50% of the charges incurred. |

b. **Inpatient Services:** 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.

| Network Benefits | Non-Network Benefits |
|---|---|
| 95% of the charges incurred. | 50% of the charges incurred. |

c. **Transitional Treatment Services:** We cover transitional treatment services described above for treatment of mental and nervous disorders.

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred, subject to a copayment of $25 per visit. | 50% of the charges incurred. |

**Substance Abuse Treatment 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 DSM 5.

a. **Outpatient Services:** We cover medically necessary outpatient professional services for diagnosis and treatment of alcoholism and other drug abuse problems. Substance abuse treatment services must be provided by a program licensed by the local Department of Health and Family Services.

Outpatient services we cover for a diagnosed substance abuse disorder 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.

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred, subject to a copayment of $25 per visit. | 50% of the charges incurred. |

We cover supervised lodging at a contracted organization for Insureds actively involved in an affiliated licensed substance abuse day treatment or intensive outpatient program for treatment of alcoholism or other drug abuse problems.

b. **Inpatient Services:** We cover medically necessary inpatient services in a hospital or a licensed residential primary treatment center.

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 Department of Health and Family Services.

| Network Benefits | Non-Network Benefits |
|---|---|
| 95% of the charges incurred. | 50% of the charges incurred. |

c. **Transitional Treatment Services:** We cover transitional treatment services described above for treatment of alcoholism or other drug abuse problems.

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred, subject to a copayment of $25 per visit. | 50% of the charges incurred. |

**Not Covered:**

- See Services Not Covered in the Group Certificate Section III.

## D. CHIROPRACTIC SERVICES

**Covered Services:**

We cover chiropractic services for rehabilitative care. Chiropractic services are adjustments to any abnormal articulations of the human body, especially those of the spinal column, for the purpose of giving freedom of action to impinged nerves that may cause pain or deranged function.

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 |
|---|---|
| 100% of the charges incurred, subject to a copayment of $25 per visit. | 50% of the charges incurred. |

**Not Covered:**

- Massage therapy for the purpose of comfort or convenience of the Insured.
- See Services Not Covered in the Group Certificate Section III.

## E. CLINICAL TRIALS

**Covered Services:**

We cover certain routine services if you participate in a Phase I, Phase II, Phase III or Phase IV approved 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. Approved clinical trials include (1) federally funded trials when the study or investigation is approved or funded by any of the federal agencies defined in the Public Health Services Act, section 2709 (d) (1) (A); (2) the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; and (3) the study or investigation is a drug trial that is exempt from having such an investigational new drug application. We cover routine patient costs for services that would be eligible under the Group Certificate 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 or experimental 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 Certificate Section III.

## F. DENTAL SERVICES

**Covered Services:**

We cover services described below.

**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 Insured was involved. We cover initial exam, x-rays and palliative treatment including extractions, and other oral surgical procedures directly related to the accident. Subsequent treatment must be initiated within the policies 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 rehabilitations 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 |
|---|---|
| 80% 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 |
|---|---|
| 100% of the charges incurred, subject to a copayment of $25 per visit. | 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 an Insured 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. The following are examples, though not all-inclusive, of medical conditions which may require hospitalization for dental services: severe asthma, severe airway obstruction or hemophilia. Hospitalization required due to the behavior of the Insured or due to the extent of the dental procedure is not covered.

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| 95% 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** |
|---|---|
| 100% of the charges incurred, subject to a copayment of $25 per visit. | 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, and any other oral surgery procedures provided as medically necessary dental services.

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| 100% of the charges incurred, subject to a copayment of $25 per visit. | 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, including orthodontic treatment and oral surgery directly related to the cleft. Dental services which are not required for the treatment of cleft lip or cleft palate are not covered. If a dependent child covered under the Group Certificate 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** |
|---|---|
| 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. |

**Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD):** We cover diagnostic procedures, surgical treatment and non-surgical treatment (including intraoral splint therapy devices) for 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** |
|---|---|
| 95% 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.
- See Services Not Covered in the Group Certificate Section III.

## G. 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 or facility will obtain or verify prior authorization for these services, 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 |
|---|---|
| 95% of the charges incurred. | 50% of the charges incurred. |

**b. All Other Outpatient Diagnostic Imaging Services**

**Services for Illness or Injury**

| Network Benefits | Non-Network Benefits |
|---|---|
| 95% of the charges incurred. | 50% of the charges incurred. |

**Preventive Services (MRI/CT procedures are not considered preventive)**

| |
|---|
| Diagnostic imaging for preventive services is covered at the benefit level shown in the Preventive Services section of this Benefits Chart. |

**Not Covered:**

- See Services Not Covered in the Group Certificate Section III.

## H. DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

**Covered Services:**

We cover equipment and services, as described below.

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 Insureds with gestational, Type I or Type II diabetes.

We cover external hearing aids (including osseointegrated or bone anchored) for Insureds under 18 years of age 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 |
|---|---|
| 95% of the charges incurred. | 50% of the charges incurred. |

| |
|---|
| *No more than a 93-day supply of diabetic supplies are covered and dispensed at a time.* |

**Special Dietary Treatment for Phenylketonuria (PKU) if it meets our medical coverage criteria**

| Network Benefits | Non-Network Benefits |
|---|---|
| 95% of the charges incurred. | 50% of the charges incurred. |

**Oral Amino Acid Based Elemental Formula if it meets our medical coverage criteria**

| Network Benefits | Non-Network Benefits |
|---|---|
| 95% 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 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 Insureds 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 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 medical 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.

**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 the Group Certificate. This exclusion does not apply to cochlear implants or pediatric eyewear, which are covered as described in the medical coverage criteria. Medical coverage criteria is available by calling Member Services, or logging on to your "myHealthPartners" 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 Certificate Section III.

## I. 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 the Group Certificate.

**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.

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred, subject to a copayment of $25 per office visit. | 50% of the charges incurred. |

**Emergency Care.** These are services to treat:

- 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
- 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.

**a. Emergency Care in a Hospital Emergency Room, including professional services of a physician**

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred, subject to a copayment of $100 per visit.<br><br>Emergency room copayment is waived if admitted for the same condition within 24 hours. | See Network Benefits. |

**b. Inpatient Emergency Care in a Hospital**

| Network Benefits | Non-Network Benefits |
|---|---|
| 95% of the charges incurred. | See Network Benefits. |

**Not Covered:**

- See Services Not Covered in the Group Certificate Section III.

## J. HEALTH EDUCATION

**Covered Services:**

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

**Provider Office Visit/Session in connection with Preventive Services**

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred. | 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. | 50% of the charges incurred. |

**Not Covered:**

- See Services Not Covered in the Group Certificate Section III.

## K. 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 prenatal 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.

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 this 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.

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

## Benefits Chart

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.

Home health services are not provided as a substitute for a primary caregiver in the home or as relief (respite) for a primary caregiver in the home. We will not reimburse family members or residents in your home for the above services.

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

**Physical Therapy, Occupational Therapy, Speech Therapy, Respiratory Therapy, Home Health Aide Services and Palliative Care**

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| 100% of the charges incurred, subject to a copayment of $25 per visit. | 50% of the charges incurred. |

**TPN/IV Therapy, Skilled Nursing Services, Non-Routine Prenatal/Postnatal Services, and Phototherapy**

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| 100% 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 Prenatal, Routine Postnatal Services and Child Health Supervision Services**

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| 100% of the charges incurred. | 50% of the charges incurred. |

**Maximum Visits for Palliative Care**

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| If you are eligible to receive palliative care in the home and you are not homebound, there is a maximum of 12 visits per calendar year. | If you are eligible to receive palliative care in the home and you are not homebound, there is a maximum of 12 visits per calendar year. |

*Each visit provided under the Network Benefits and Non-Network Benefits counts toward the maximums shown under both Maximum visits sections.*

**Maximum Visits for All Other Services**

| Network Benefits | Non-Network Benefits |
|---|---|
| 60 visits per calendar year. | 30 visits per calendar year. |

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

**Not Covered:**

- Financial or legal counseling services.
- Housekeeping or meal services in your home.
- Private duty nursing services.
- 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 Certificate Section III.

## L. 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.

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| 100% 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.
- Housekeeping or meal services in your home.
- Custodial or maintenance care related to hospice services, whether provided in the home or in a nursing home.
- Any service not specifically described as covered services under this home hospice services benefits.
- Any services provided by members of your family or residents in your home.
- See Services Not Covered in the Group Certificate Section III.

## M. 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, 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.

## Benefits Chart

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** |
|---|---|
| 95% of the charges incurred. | 50% of the charges incurred. |

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

**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 colonoscopies (starting at age 50, or under age 50 for people at high risk of colorectal cancer), and 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 or facility will obtain or verify prior authorization for these services, as needed.

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| 95% 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 Benefits 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. Rehabilitation services are limited to services where significant measurable progress is expected to occur within a reasonable period of time.

| Network Benefits | Non-Network Benefits |
|---|---|
| 95% of the charges incurred.<br><br>Limited to 30 day maximum per period of confinement. | 50% of the charges incurred.<br><br>Limited to 15 day maximum per period of confinement. |

*Each day of services provided under the Network 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 Certificate Section III.

## N. 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 |
|---|---|
| 95% 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 do cover office visits and consultations to diagnose infertility.
- Services related to the establishment of surrogate pregnancy and fees for a surrogate.
- All drugs used for the treatment of infertility.
- See Services Not Covered in the Group Certificate Section III.

## O. LABORATORY SERVICES

**Covered Services:**

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

*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 |
|---|---|
| 100% of the charges incurred. | 50% of the charges incurred. |

**Preventive Services**

Laboratory for preventive services is covered at the benefit level shown in the Preventive Services section of this Benefits Chart.

**Not Covered:**

- See Services Not Covered in the Group Certificate 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 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:**

- See Services Not Covered in the Group Certificate Section III.

## 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.

## Benefits Chart

We cover diagnosis and treatment of illness or injury to the eyes. Where contact or eye glass 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. Insureds must pay for lens replacement beyond the initial pair.

**Office Visits**

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred, subject to a copayment of $25 per office visit. | 50% of the charges incurred. |

**Convenience Clinics**

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred, subject to a copayment of $10 per office visit. | 50% of the charges incurred. |

**Scheduled Telephone Visits**

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred, subject to a copayment of $10 per visit. | 50% of the charges incurred. |

**E-Visits**

**a. Access to Online Care through virtuwell at www.virtuwell.com**

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred. | No coverage. |

**b. All Other E-Visits**

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred, subject to a copayment of $10 per visit. | 50% of the charges incurred. |

**Injections Administered in a Physician's Office, other than immunizations**

**a. Allergy Injections**

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred. | 50% of the charges incurred. |

**b. All Other Injections**

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred. | 50% of the charges incurred. |

**Not Covered:**

- Court ordered treatment, except as described in this Benefits Chart section C., subsection "Mental Health Services" or as otherwise required by law. Any resulting court ordered treatment for mental health services will be subject to the Group Certificate's requirement for medical necessity.
- See Services Not Covered in the Group Certificate Section III.

## R. PEDIATRIC EYEWEAR

**Covered Services:**

We cover pediatric eyewear for children under age 19, subject to our medical coverage criteria. Coverage under 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 "*my*HealthPartners" account at www.healthpartners.com.

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| 95% of the charges incurred. | No coverage. |

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

**Not Covered:**

- Replacement of eyeglasses or contact lenses due to loss or theft.
- Contact lenses for cosmetic purposes.
- See Services Not Covered in the Group Certificate 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. Medically necessary 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 or 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.)*

## Benefits Chart

### Rehabilitative Care

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred, subject to a copayment of $25 per visit.<br><br>Physical and Occupational Therapy combined are limited to 40 visits per calendar year.<br><br>Speech Therapy is limited to 20 visits per calendar year. | 50% of the charges incurred.<br><br>Physical and Occupational Therapy combined are limited to 20 visits per calendar year.<br><br>Speech Therapy is limited to 20 visits per calendar year. |

### Habilitative Services

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred, subject to a copayment of $25 per visit.<br><br>Physical and Occupational Therapy combined are limited to 40 visits per calendar year.<br><br>Speech Therapy is limited to 20 visits per calendar year. | 50% of the charges incurred.<br><br>Physical and Occupational Therapy combined are limited to 20 visits per calendar year.<br><br>Speech Therapy is limited to 20 visits per calendar year. |

**Not Covered:**

- Massage therapy for the purpose of comfort or convenience of the Insured.
- See Services Not Covered in the Group Certificate Section III.

## Benefits Chart

### T. PRESCRIPTION DRUG SERVICES

**Covered Services:**

We cover prescription drugs and medications, which can be self-administered or are administered in a physician's office.

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

**Outpatient Drugs (other than tobacco cessation drugs, contraceptive drugs and specialty drugs)**

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred, subject to a 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 copayment of $100. | 50% of the charges incurred. |

**Oral chemotherapy drugs** are included on the Specialty Drug List. However, you pay the applicable outpatient drug copayment. As required by Wisconsin law, your maximum copayment will not be more than $100 per prescription for a 30-day supply.

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

**Tobacco Cessation Drugs**

| Network Benefits | Non-Network Benefits |
|---|---|
| Formulary drugs:<br>100% of the charges incurred. | 50% of the charges incurred. |

## Benefits Chart

### 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.<br><br>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.<br><br>Specialty Drugs are not available through the mail order service. | See Network Mail Order Drugs Benefit. |

### Contraceptive Drugs

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred for formulary drugs.<br><br>If a physician requests that a non-formulary contraceptive drug be dispensed as written, the drug will be covered at 100%. | 50% of the charges incurred. |

### Specialty Drugs which are self-administered

| Network Benefits | Non-Network Benefits |
|---|---|
| 80% of the charges incurred, up to a maximum copayment of $200. | See Non-Network Outpatient Drugs Benefit. |

*Specialty Drugs are limited to drugs on the Specialty Drug List and must be obtained from a designated vendor.*

**Oral chemotherapy drugs** are included on the Specialty Drug List. However, you pay the applicable outpatient drug copayment. As required by Wisconsin law, your maximum copayment will not be more than $100 per prescription for a 30-day supply.

**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. 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 unless specified on the Specialty Drug List.*

- *If an Insured 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.*
- *If a copayment is required, you must pay one 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. This exclusion does not include over-the-counter contraceptives for women as allowed under the Affordable Care Act when the Insured obtains a prescription for the item. In addition, if the Insured 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 age 6-12 who are at risk for anemia.
- All drugs used for sexual dysfunction.
- All drugs for the treatment of infertility.
- Drugs for the treatment of growth deficiency.
- All non-sedating oral antihistamines for which there are over-the-counter alternatives.
- Medical cannabis.
- See Services Not Covered in the Group Certificate Section III.

## U. PREVENTIVE SERVICES

**Covered Services:**

We cover preventive services which meet any of the requirements under the Affordable Care Act (ACA) shown in the bulleted items below. These preventive services are covered at 100% under the Network Benefits with no deductible, copayments or coinsurance. (If a preventive service is not required by the ACA and it is covered at a lower benefit level, it will be specified below.) Preventive benefits mandated under the ACA are subject to periodic review and modification. Changes would be effective in accordance with the federal rules. Preventive services mandated by the ACA include:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual;
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

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.

## Benefits Chart

In addition to any ACA mandated preventive services referenced above, we cover the following eligible preventive services.

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 counseling for tobacco cessation.

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| 100% of the charges incurred. | 50% of the charges incurred. |

2. **Child Health Supervision Services,** including pediatric preventive services, routine immunizations, developmental assessments and laboratory services appropriate to the age of the child from birth to 72 months, and appropriate immunizations to age 18.

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| 100% of the charges incurred. | 50% of the charges incurred. |

3. **Routine Prenatal Services and Exams** to include visit-specific screening tests, education and counseling.

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| 100% of the charges incurred. | 50% of the charges incurred. |

4. **Routine Postnatal Services 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. | 50% of the charges incurred. |

5. **Routine Screening Procedures for Cancer** including mammograms and Pap smears. For women ages 45 to 49 we cover a minimum of 2 mammograms and mammograms annually for women age 50 and older. We also cover colonoscopies starting at age 50, and under age 50 for people at high risk of colorectal cancer.

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| 100% of the charges incurred. | 50% of the charges incurred. |

6. **Routine Eye and Hearing Exams**

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| 100% of the charges incurred. | 50% of the charges incurred. |

7. **Professional Voluntary Family Planning Services**

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| 100% of the charges incurred. | 50% of the charges incurred. |

**8. Adult Immunizations**

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred. | 100% of the charges incurred. |

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

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred. | 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 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 the services.

| Network Benefits | Non-Network Benefits |
|---|---|
| 100% of the charges incurred. | 50% of the charges incurred. |

**Not Covered:**

- See Services Not Covered in the Group Certificate Section III.

## V. 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 Insureds.

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

## Benefits Chart

**Covered Services:**

We cover eligible transplant services (as defined above) while you are covered under this Certificate. 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.

To receive Network Benefits, charges for transplant services must be incurred at a Designated Transplant Center.

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

Medical and hospital expenses of the donor are covered only when the recipient is an Insured 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 Insureds, and are therefore not eligible for the rights afforded to Insureds under the Group Certificate.

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

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

**Kidney disease treatment.** We cover services for kidney disease treatment, including dialysis, transplantation and donor related services. Donor related expenses are covered as described above.

| **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:**

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

## W. 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 network pharmacist.

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

| **Network Benefits** | **Non-Network Benefits** |
|---|---|
| 100% of the charges incurred. | No coverage. |

**Not Covered:**

- See Services Not Covered in the Group Certificate Section III.