HealthPartners Insurance Company
Gold
Minnesota Small Employer Plan
Benefits Chart

NOTICE: THIS DISCLOSURE IS REQUIRED BY MINNESOTA LAW. THIS POLICY IS EXPECTED TO RETURN ON AVERAGE 88.7 PERCENT OF YOUR PAYMENT DOLLAR FOR HEALTH CARE. THE LOWEST PERCENTAGE PERMITTED BY STATE LAW FOR THIS POLICY IS 82 PERCENT.

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 below. This 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 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 healthpartners.com.

Benefits are underwritten by HealthPartners Insurance Company.

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

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.

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, most 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 this 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 name drug. Biosimilar drugs are not considered generic drugs and are not covered under the generic drug benefit.

Brand Name 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 name 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 name drug has expired. A few brand name drugs may be covered at the generic drug benefit level if this is indicated on the formulary.

Calendar Year: This is the 12-month period beginning 12:01 A.M. Central Time, on January 1, and ending 12:00 A.M. Central Time of the next following December 31.

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 covered services delivered by non-network providers, a contracted rate may apply if such arrangement is available to HealthPartners.

For the Usual and Customary Charge for covered services delivered by non-network providers, our payment is calculated using one of the following options to be determined at HealthPartners' discretion: 1) a percentage of the Medicare fee schedule, 2) a comparable schedule if the service is not on the Medicare fee schedule, or 3) a commercially reasonable rate for such service.

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 this Benefits Chart.

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 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.

Any amounts paid or reimbursed by a third party, including but not limited to: point of service rebates, manufacturer coupons, manufacturer debit cards or other forms of direct reimbursement to an insured for a product or service, will not apply toward your deductible, to the extent permitted under state and federal law.

Your plan has an embedded deductible. This means once an insured meets the individual deductible, the plan begins paying benefits for that person. If two or more members of the family meet the family deductible, the plan begins paying benefits for all members of the family, regardless of whether each insured has met the individual deductible. However, an insured may not contribute more than the individual deductible toward the family deductible..

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

Formulary:

This is a current list, which may be revised from time to time, of prescription drugs, medications, equipment and supplies covered by us as indicated in this 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. You will be granted an exception to the formulary as described in the formulary exception process shown below 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. 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 healthpartners.com.

Formulary Exception Process for Antipsychotic Drugs.

If you are prescribed an antipsychotic drug, we must promptly grant you an exception to our formulary when your health care provider indicates to us that:

- the formulary drug causes an adverse reaction to the patient;
- the formulary drug is contraindicated for the patient; or
- the health care provider demonstrates that the prescription drug must be dispensed as written to provide maximum medical benefit to the patient.

NOTE: If you are a new enrollee under the plan or the plan formulary changes so that you are receiving a prescribed drug to treat a diagnosed mental illness or emotional disturbance that is not or is no longer on the formulary, you may continue to receive the prescribed drug for up to one year without the imposition of a special deductible, copayment, coinsurance or other special copayment requirements that would apply to non-formulary drugs. This provision applies if:

- you have been treated with the drug for 90 days prior to a change in our formulary or a change in your health plan;
- the health care provider prescribing the drug indicates to the dispensing pharmacist, orally or in writing that the prescription must be dispensed as communicated; and
- the health care provider prescribing the drug certifies in writing to us that the drug prescribed will best treat your condition.

Generic Drug:

A prescription drug, approved by the Food and Drug Administration (FDA), that the FDA has determined is comparable to a brand name drug product in dosage form, strength, route of administration, quality, intended use and documented bioequivalence. Generally, generic drugs cost less than brand name drugs. Some brand name 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 Benefits Chart.

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 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.

Any amounts paid or reimbursed by a third party, including but not limited to: point of service rebates, manufacturer coupons, manufacturer debit cards or other forms of direct reimbursement to an insured for a product or service, will not apply as an out of pocket expense, to the extent permitted under state and federal law.

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 Certificate.

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 in this Benefits Chart. The specialty drug list is available by calling Member Services, or logging on to your "*my*HealthPartners" account at healthpartners.com.

virtuwell: This 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 virtuwell.com.

DEDUCTIBLES AND OUT-OF-POCKET LIMITS

Individual Calendar Year Deductible

Network Benefits	Non-Network Benefits
$2,000	$10,000

Family Calendar Year Deductible

Network Benefits	Non-Network Benefits
$6,000	$20,000

A separate deductible must be satisfied under the Network Benefits and Non-Network Benefits.

Your plan has an embedded deductible. This means once an insured meets the individual deductible, the plan begins paying benefits for that person. If two or more members of the family meet the family deductible, the plan begins paying benefits for all members of the family, regardless of whether each insured has met the individual deductible. However, an insured may not contribute more than the individual deductible toward the family deductible.

Any amounts paid or reimbursed by a third party, including but not limited to: point of service rebates, manufacturer coupons, manufacturer debit cards or other forms of direct reimbursement to an insured for a product or service, will not apply toward your deductible, to the extent permitted under state and federal law.

Individual Calendar Year Out-of-Pocket Limit

Network Benefits	Non-Network Benefits
$6,500	$30,000

Family Calendar Year Out-of-Pocket Limit

Network Benefits	Non-Network Benefits
$13,000	$60,000

A separate Out-of-Pocket Limit must be satisfied under the Network Benefits and Non-Network Benefits.

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

Any amounts paid or reimbursed by a third party, including but not limited to: point of service rebates, manufacturer coupons, manufacturer debit cards or other forms of direct reimbursement to an insured for a product or service, will not apply as an out of pocket expense, to the extent permitted under state and federal law.

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 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 healthpartners.com.

Ambulance and medical transportation (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 Certificate.

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 healthpartners.com.

You have rights to parity in mental health and substance use disorder treatment as required by the federal Mental Health Parity and Addiction Equity Act and Minnesota Statutes, section 62Q.47. These laws require:

- That mental health and substance abuse services be covered on the same basis as medical services;
- That cost-sharing for mental health and substance abuse services can be no more restrictive than cost-sharing for similar medical services;
- That treatment restrictions and limitation such as prior authorization and medical necessity can be no more restrictive than for similar medical services;
- That if enrollees have concerns they can call Member Services, file a complaint with HealthPartners, or file a complaint with the Minnesota Department of Commerce.

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).

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.

Outpatient Services including intensive outpatient and day treatment 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:

- Individual, group, family, and multi-family therapy;
- Medication management provided by a physician, certified nurse practitioner, or physician's assistant;
- Psychological testing services for the purposes of determining the differential diagnoses and treatment planning for patients currently receiving behavioral health services;
- Day treatment and intensive outpatient services in a licensed program;
- Partial hospitalization services in a licensed hospital or community mental health center;
- Psychotherapy and nursing services provided in the home if authorized by us; and
- Treatment for gender dysphoria that meets medical coverage criteria.

Network Benefits	**Non-Network Benefits**
100% of the charges incurred, subject to your copayment of $50 per visit. Deductible does not apply. 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 your copayment of $25 per visit. Deductible does not apply.	50% of the charges incurred.

Inpatient Services, including psychiatric residential treatment: 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 also cover medically necessary psychiatric residential treatment for adults and emotionally disabled children as diagnosed by a physician. This care must be authorized by us and provided by a hospital or residential behavioral health treatment facility licensed by the local state or Health and Human Services Department. For purposes of this provision, "emotionally disabled child" shall have the meaning set forth by the commissioner of human services in the rules relating to residential treatment facilities. Services not covered under this benefit include shelter services, correctional services, detention services, transitional services, group homes, 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 DSM 5.

We also cover chemical dependency treatment provided to an enrollee by the Department of Corrections while the enrollee is committed to the custody of the commissioner of corrections following a conviction for a first-degree driving while impaired offense, as required under Minnesota Statute 62Q.137.

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:

- Individual, group, family, and multi-family therapy provided in an office setting;
- Opiate replacement therapy including methadone and buprenorphine treatment; and
- Day treatment and intensive outpatient services in a licensed program.

Network Benefits	Non-Network Benefits
100% of the charges incurred, subject to your copayment of $50 per visit. Deductible does not apply. 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.

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.

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 Certificate.

CHIROPRACTIC SERVICES

Covered Services:

We cover chiropractic services for rehabilitative and habilitative 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 your copayment of $50 per visit. Deductible does not apply.	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 insured.
- See "Services Not Covered" in the Group Certificate.

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 Benefits Chart 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 Certificate.

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 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 specified 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
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 24 months of the date of injury to be covered.

Medical Referral Dental Services

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 your copayment of $50 per visit. Deductible does not apply.	50% of the charges incurred.

Medically Necessary Hospitalization and Anesthesia for Dental Care: We cover medically necessary hospitalization and anesthesia for dental care.

We cover anesthesia and hospital charges for dental care incurred by an insured who: (1) is a child under age 5; (2) is severely disabled; or (3) has a medical condition and requires hospitalization or general anesthesia for dental care treatment.

In addition, we cover anesthesia and hospital charges for dental care incurred for an insured who 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 four appointments, are required. The requirement of a hospital setting must be due to an insured's underlying medical condition. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist professional fees are not covered.

Anesthesia is covered in a hospital or dental office. 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. Except as described above, 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
70% of the charges incurred.	50% of the charges incurred.

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 your copayment of $50 per visit. Deductible does not apply.	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 your copayment of $50 per visit. Deductible does not apply.	50% of the charges incurred.

Treatment of Cleft Lip and Cleft Palate of a Dependent Child: 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 the 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
100% of the charges incurred, subject to your copayment of $50 per visit. Deductible does not apply.	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 and administered or prescribed by a physician or dentist. Dental services which are not required to directly treat TMD or CMD are not covered.

Network Benefits	Non-Network Benefits
100% of the charges incurred, subject to your copayment of $50 per visit. Deductible does not apply.	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 24 months from the date of injury.
- Oral surgery to remove wisdom teeth, except as stated in the Pediatric Dental Amendment.
- Orthognathic treatment or procedures and all related services, unless it is required to treat TMD, CMD, cleft lip and cleft palate, and it meets our medical coverage criteria.
- See “Services Not Covered” in the Group Certificate.

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 Computed 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).

Outpatient Magnetic Resonance Imaging (MRI) and Computed Tomography (CT)

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

All other outpatient diagnostic imaging services

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)

Diagnostic imaging services associated with preventive services are 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.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

Covered Services:

We cover equipment, supplies and services, as described below. Certain items are only covered if your condition meets our coverage criteria. For more information on what we cover and any prior authorization requirements, call Member Services or log on to your “*my*HealthPartners” account athealthpartners.com.

- Durable medical equipment, such as wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices, hospital beds, and related services.
- Prosthetics, including breast prostheses, artificial limbs and artificial eyes, and related supplies.
- Hair prostheses (wigs) for hair loss resulting from alopecia areata.
- Orthotics.
- Medical supplies, including splints, surgical stockings, casts and dressings.
- Enteral feedings.
- All physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes for insureds with gestational, Type I or Type II diabetes.

Diabetic supplies purchased at a pharmacy

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

Diabetic supplies purchased from a non-pharmacy provider

Network Benefits	**Non-Network Benefits**
70% of the charges incurred if purchased from an approved vendor.	50% of the charges incurred.

Special dietary treatment for Phenylketonuria (PKU) if it is recommended by a physician

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.

All other durable medical equipment, prosthetics, orthotics and supplies

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.
- No more than a 93-day supply of diabetic supplies are covered and dispensed at a time.
- Wigs for hair loss resulting from alopecia areata are limited to one per calendar year.
- 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 insureds to conduct standard activities of daily living.
- We reserve the right to determine if an item will be approved for rental vs. purchase.
- We require that certain diabetic supplies and equipment be purchased at a pharmacy.
- 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 "myHealthPartners" account at 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, speech processors, receivers, communication boards, or computer or electronic assisted communication.
- Hearing aids (implantable and external, including osseointegrated or bone anchored) and their fitting, except as described in this Benefits Chart under "External Hearing Aids for Insureds Age 18 or Younger." This exclusion does not apply to cochlear implants.
- Eyeglasses, contact lenses and their fitting, measurement and adjustment, except as described in this Benefits Chart under "Pediatric Eyewear."
- Hair prostheses (wigs), except as specifically described in this Benefits Chart.
- 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.

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 Benefits Chart.

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
100% of the charges incurred, subject to your copayment of $50 per visit. Deductible does not apply.	See Network Benefits.

Emergency Care. This is service to treat a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, would believe requires immediate medical attention to:

- Prevent placing your health in serious jeopardy,
- Prevent serious impairment to your bodily functions, or
- Prevent serious dysfunction of any of your bodily organs or parts.

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.

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.

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 Certificate.

EXTERNAL HEARING AIDS FOR INSUREDS AGE 18 OR YOUNGER

Covered Services:

We cover external hearing aids (including osseointegrated or bone anchored) for insureds 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.

Limitations:

- Payment will not exceed the cost of an alternate hearing aid that is effective and medically necessary.

Not Covered:

- See "Services Not Covered" in the Group Certificate.

GENE THERAPY

Covered Services:

We cover gene therapy treatment that meets our current medical coverage criteria.

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.	No coverage.

Limitations:

- Gene therapy must be provided by a designated provider.
- Specific types of gene therapy are limited to therapies and conditions specified in our medical coverage criteria.

Not Covered:

- See "Services Not Covered" in the Group Certificate.

HEALTH EDUCATION

Covered Services:

We cover education for preventive services and education for the management of chronic health problems (such as diabetes). Coverage includes diabetes outpatient self-management training and education including medical nutrition therapy that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association for persons with gestational, type I or type II 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 Certificate.

HOME-BASED COMPREHENSIVE HEALTH RISK ASSESSMENT

Covered Services:

If you meet our criteria for coverage, you may qualify for our home-based comprehensive health risk assessment program. The program covers a health assessment with a designated nurse practitioner.

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 Certificate.

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 our 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.

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 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.

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

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 your copayment of $50 per visit. Deductible does not apply.	50% of the charges incurred.

If more than one home health visit occurs in a day, a separate copayment applies to each. For example, if an occupational therapist and a physical therapist visit an insured in the same day, a separate copayment will be charged for each visit.

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

Network Benefits	Non-Network Benefits
100% of the charges incurred. Deductible does not apply.	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 both Maximum visits sections. The routine postnatal well child visit does not count toward the visit limit.

Limitations:

- 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 this Benefits Chart.

Not Covered:

- Financial or legal counseling services.
- Housekeeping or meal services in your home.
- Private duty nursing services. This exclusion does not apply if an insured is also covered under Medical Assistance under Minnesota chapter 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 Certificate.

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.

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.

Eligible Services: Hospice services include the following services provided in accordance with an approved hospice treatment plan.

- Home Health Services:
  - 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.
  - 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.
- Inpatient Services: We cover medically necessary inpatient services.
- Other Services:
  - 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.
  - Medically necessary medications for pain and symptom management.
  - Semi-electric hospital beds and other durable medical equipment are covered.
  - Emergency and non-emergency care is covered.

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

Respite care is limited to five 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.

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 four 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 a 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 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 gender reassignment surgery that meets medical coverage criteria.

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

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.

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

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 calendar year.	50% of the charges incurred. Limited to 120 day maximum per calendar year.

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

Not Covered:

- Services for items for personal convenience, such as television rental.
- See "Services Not Covered" in the Group Certificate.

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. Deductible does not apply.	See Network Benefits.

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

Not Covered:

- Treatment of infertility, including but not limited to office visits, laboratory and diagnostic imaging services and drugs for the treatment of infertility, 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; reversal of sterilization; artificial insemination; 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. However, pregnancy and maternity services are covered for an insured under this Benefits Chart, including a surrogate pregnancy.
- See “Services Not Covered” in the Group Certificate.

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.

Prostate-specific antigen (PSA) test coverage. We cover prostate cancer screening for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older. Coverage includes a prostate-specific antigen blood test and a digital rectal examination.

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

All other laboratory services

Services for illness or injury

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

Preventive services

Laboratory services associated with preventive services are 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.

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 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.

MASTECTOMY RECONSTRUCTION BENEFIT

Covered Services:

We cover reconstruction of the breast on which the mastectomy has been performed if the mastectomy is medically necessary as determined by the attending physician. We also cover surgery and reconstruction of the other breast to produce symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and patient.

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.

MEDICATION THERAPY DISEASE MANAGEMENT PROGRAM

Covered Services:

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 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 Certificate.

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. Insureds 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
100% of the charges incurred, subject to your copayment of $50 per visit. Deductible does not apply.	50% of the charges incurred.

Convenience clinics

Network Benefits	Non-Network Benefits
100% of the charges incurred, subject to your copayment of $25 per visit. Deductible does not apply.	50% of the charges incurred.

Scheduled telephone visits

Network Benefits	Non-Network Benefits
100% of the charges incurred, subject to your copayment of $25 per visit. Deductible does not apply.	50% of the charges incurred.

E-visits

Access To Online Care through virtuwell at virtuwell.com

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

All other E-visits

Network Benefits	Non-Network Benefits
100% of the charges incurred, subject to your copayment of $25 per visit. Deductible does not apply.	50% of the charges incurred.

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

Allergy injections

Network Benefits	Non-Network Benefits
100% of the charges incurred, subject to your copayment of $2 per date of service. Deductible does not apply.	50% of the charges incurred.

All other injections

Network Benefits	Non-Network Benefits
100% of the charges incurred, subject to your copayment of $2 per date of service. Deductible does not apply.	50% of the charges incurred.

Not Covered:

- Court ordered treatment, except as described in this Benefits Chart under "Mental Health Services" and "Office Visits for Illness or Injury" or as otherwise required by law.
- See "Services Not Covered" in the Group Certificate.

PEDIATRIC AUTOIMMUNE NEUROPSYCHIATRIC DISORDERS ASSOCIATED WITH STREPTOCOCCAL INFECTIONS (PANDAS) AND PEDIATRIC ACUTE-ONSET NEUROPSYCHIATRIC SYNDROME (PANS) TREATMENT

Definitions:

Pediatric acute-onset neuropsychiatric syndrome. This means a class of acute-onset obsessive compulsive or tic disorders or other behavioral changes presenting in children and adolescents that are not otherwise explained by another known neurologic or medical disorder.

Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections. This means a condition in which a streptococcal infection in a child or adolescent causes the abrupt onset of clinically significant obsessions, compulsions, tics, or other neuropsychiatric symptoms or behavioral changes, or a relapsing and remitting course of symptom severity**.**

Covered Services:

We cover treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS). Treatments that must be covered under this section must be recommended by the insured's licensed health care professional and include but are not limited to antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.

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 Certificate.

PEDIATRIC EYEWEAR

Covered Services:

We cover pediatric eyewear for children 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. We also cover low vision services. These medical policies (medical coverage criteria) are available by calling Member Services, or logging on to your "*my*HealthPartners" account at 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 contacts per benefit year.

Not Covered:

- Replacement of eyeglasses or contact lenses due to loss or theft.
- See "Services Not Covered" in the Group Certificate.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY

Covered Services:

We cover the following physical therapy, occupational therapy and speech therapy services:

- Medically necessary rehabilitative care to correct the effects of illness or injury.
- 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.

Rehabilitative Care

Network Benefits	**Non-Network Benefits**
100% of the charges incurred, subject to your copayment of $50 per visit. Deductible does not apply.	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.

Habilitative Care

Network Benefits	**Non-Network Benefits**
100% of the charges incurred, subject to your copayment of $50 per visit. Deductible does not apply.	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 insured.
- See "Services Not Covered" in the Group Certificate.

PORT WINE STAIN REMOVAL SERVICES

Covered Services:

We cover port wine stain removal services.

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.

PRESCRIPTION DRUG SERVICES

Covered Services:

We cover prescription drugs and medications that 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 one of the standard reference compendia or in one article in the medical literature as defined by Minnesota Statute 62Q.525.

We cover orally administered anticancer drugs at the applicable benefit level under outpatient drugs below. We are in compliance with Minnesota Statute 62A.3075 because we do not cover orally administered anticancer drugs under our specialty drug benefit.

We will refill a prescription for eye drops covered under this Benefits Chart if the insured requests a refill and original prescription specified that additional quantities would be needed, providing the refill request does not exceed the quantities needed, and the following conditions are met:

- If the insured requests a 30-day refill supply, the request must be made between 21 and 30 days of the later of (a) the original date that the prescription was distributed to the insured or (b) the date that the most recent refill was distributed to the insured; or
- If the insured requests a 90-day refill supply, the request must be made between 75 and 90 days of the later of (a) the original date that the prescription was distributed to the insured or (b) the date that the most recent refill was distributed to the insured.

A licensed pharmacist may prescribe and dispense self-administered hormonal contraceptives, nicotine replacement medications, and opiate antagonists for the treatment of an acute opiate overdose in accordance with Minnesota Statute 62Q.529, under the same terms of coverage that would apply had the prescription drug been prescribed by a licensed physician, physician assistant, or advanced practice nurse practitioner. If the plan excludes coverage for self-administered hormonal contraceptives, they will not be covered under this provision

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

Outpatient drugs (except as specified below)

Network Benefits	**Non-Network Benefits**
100% of the charges incurred, subject to your copayment of $5 for generic low cost formulary drugs. 100% of the charges incurred, subject to your copayment of $25 for generic high cost formulary drugs. 100% of the charges incurred, subject to your copayment of $60 for brand name formulary drugs. In no event will your cost for a formulary insulin drug exceed $25. Non-formulary drugs are covered at 100% of the charges incurred, subject to your copayment of $150. Deductible does not apply.	50% of the charges incurred.

Cost Sharing Limits for Insulin: We are required to limit your cost-sharing on prescription insulin to no more than the net price of the prescription insulin drug. This requirement applies at the point of sale, including deductible payments and the cost-sharing amounts charged once the deductible is met.

Cost-sharing. This means a deductible payment, co-payment, or coinsurance amount that you must pay for covered prescription insulin in accordance with the terms and conditions of this health plan.

Net price. This means our cost for prescription insulin, including any rebates or discounts received by or accrued directly or indirectly to us from a drug manufacturer or pharmacy benefit manager.

Mail Order Drugs

Network Benefits	Non-Network Benefits
For your convenience, you may also get up to a 93-day supply of outpatient prescription drugs that can be self-administered through the designated mail order service. 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 Network Mail Order Drugs Benefit.

Tobacco cessation drugs are covered for all FDA-approved tobacco cessation drugs (including over-the-counter drugs) for a minimum of 90 days

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

Specialty Drugs that are self-administered

Network Benefits	Non-Network Benefits
80% of the charges incurred. Deductible does not apply.	No coverage.

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
80% of the charges incurred. Deductible does not apply.	50% of the charges incurred.

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, the drug will be covered at 100%, not subject to the deductible.	50% of the charges incurred.

Limitations:

- 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. The formulary drug list is a current list, which may be revised from time to time, of prescription drugs, medications, equipment and supplies. The formulary drug list is available by calling Member Services, or logging on to your "myHealthPartners" account at healthpartners.com
- 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.
- If an insured requests a brand name drug when there is a generic equivalent, the brand name 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 name drug be dispensed as written, the drug will be paid at the non-formulary benefit.
- We may require insureds to try over-the-counter (OTC) drug alternatives before approving more costly formulary prescription drugs.
- Unless otherwise specified in the Prescription Drug Services section, you may receive up to a 31-day supply per prescription.
- New prescriptions to treat certain chronic conditions are limited to a 31-day supply.
- 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 it is a manufacturer supplied drug that cannot be split that supplies the insured with more than a 31-day supply.
- If a copayment is required, you must pay one copayment for each 31-day supply, or portion thereof.

Not Covered:

- Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
- Nonprescription (over the counter) drugs or medications, including, but not limited to, vitamins, supplements, homeopathic remedies, and non-FDA approved drugs, unless listed on the formulary and prescribed by a physician or legally authorized health care provider under applicable state and federal law.
- All drugs used for sexual dysfunction.
- All drugs used for the treatment of infertility.
- Medical cannabis.
- Drugs on the Excluded Drug List. The Excluded Drug List includes select drugs within a therapy class that are not eligible for coverage. This includes drugs that may be excluded for certain indications. The Excluded Drug List is available at healthpartners.com. This exclusion does not apply to formulary exceptions for antipsychotic drugs. See definition of Formulary in this Benefits Chart.
- Drugs that are newly approved by the FDA until they are reviewed and approved by HealthPartners Pharmacy and Therapeutics Committee.
- Medical devices approved by the FDA will not be covered under the Prescription Drug Services section unless they are on our formulary. Covered medical devices are generally submitted and reimbursed under your medical benefits.
- See "Services Not Covered" in the Group Certificate.

PREVENTIVE SERVICES

Applicable Definitions:

Routine Preventive Services are routine healthcare services that include screenings, check-ups and counseling to prevent illness, disease or other health problems before symptoms occur.

Diagnostic Services are services to help a provider understand your symptoms, diagnose illness and decide what treatment may be needed. They may be the same services that are listed as preventive services, but they are being used as diagnostic services. Your provider will determine if these services are preventive or diagnostic. These services are not preventive if received as part of a visit to diagnose, manage or maintain an acute or chronic medical condition, illness or injury. When that occurs, unless indicated below, standard deductibles, copayments or coinsurance apply.

Covered Services:

We cover preventive services that 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, or if a group qualifies for an exemption or accommodation for certain benefits under the ACA, 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 healthpartners.com.

ACA and state mandated preventive services are covered as follows:

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 screening for tobacco use, at least two tobacco cessation attempts per year (for those who use tobacco products), all FDA approved tobacco cessation medications including over-the-counter drugs (as shown in the Prescription Drugs Services section) and at least four counseling sessions of at least ten minutes each for tobacco cessation.

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

Child health supervision services. This includes pediatric preventive services such as fluoride chemoprevention for children without fluoride in their water source, newborn screenings, appropriate immunizations, developmental assessments and laboratory services appropriate to the age of the child from birth to 72 months, and appropriate immunizations to age 18, as defined by the Standards of Child Health Care issued by the American Academy of Pediatrics. We cover at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, once a year from 24 months to 72 months.

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

Routine prenatal care and exams. This includes the comprehensive package of medical and psychosocial support provided throughout a pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

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

Routine postnatal care. This includes 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.

Routine screening procedures for cancer. This includes colorectal screening or other cancer screenings recommended by the USPSTF with an A or B rating. Women's preventive health services below describes additional routine screening procedures for cancer.

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

Professional voluntary family planning services. This includes services to prevent or delay a pregnancy, including counseling and education. Services must be provided by a licensed provider.

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

Adult immunizations

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

Women's preventive health services. This includes mammograms, screenings for cervical cancer (pap smears), breast pumps; human papillomavirus (HPV) testing; counseling for sexually transmitted infections, and counseling and screening for human immunodeficiency virus (HIV), and all FDA approved contraceptive methods as prescribed by a doctor, sterilization procedures, education and counseling needed for the provision of the contraceptive method (see the Prescription Drug Services section for coverage of oral contraceptive drugs). For women whose family history is associated with an increased risk for BRCA1 or BRCA2 gene mutations, we cover genetic counseling and BRCA screening without cost sharing, if appropriate and as determined by a physician.

*****Preventive mammogram screening includes digital breast tomosynthesis (3D mammograms) for insureds at risk for breast cancer.

"At risk for breast cancer" means: (1) having a family history with one or more first- or second-degree relatives with breast cancer; (2) testing positive for BRCA1 or BRCA2 mutations; (3) having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or (4) having a previous diagnosis of breast cancer.

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

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 these services.

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

Preventive Medications. We cover preventive medications currently recommended by USPSTF with an A or B rating if they are prescribed by your medical provider and they are listed on our formulary. Preventive medications are subject to periodic review and modification. Changes would be effective in accordance with the federal rules and reflected in our current medical coverage criteria for preventive care services.

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

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

Routine eye and hearing exams

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

Ovarian cancer surveillance tests for women who are at risk. "At risk for ovarian cancer" means (1) having a family history that includes any of the following: one or more first-degree or second-degree relatives with ovarian cancer, clusters of female relatives with breast cancer or nonpolyposis colorectal cancer; or (2) testing positive for BRCA1 or BRCA2 mutations. "Surveillance tests for ovarian cancer" means annual screening using: CA-125 serum tumor marker testing, transvaginal ultrasound, pelvic examination or other proven ovarian cancer screening tests currently being evaluated by the federal Food and Drug Administration or by the National Cancer Institute.

Network Benefits	Non-Network Benefits
Coverage level is same as corresponding Network Benefit, depending on type of service provided, such as Diagnostic Imaging Services, Laboratory Services Office Visits for Illness or Injury or Preventive Services.	Coverage level is same as corresponding Non-Network Benefit, depending on type of service provided, such as Diagnostic Imaging Services, Laboratory Services Office Visits for Illness or Injury or Preventive Services.

Limitations:

- Services are not preventive if received as part of a visit to diagnose, manage or maintain an acute or chronic medical condition, illness or injury. When that occurs, unless otherwise indicated above, standard deductibles, copayments or coinsurance apply.

Not Covered:

- See "Services Not Covered" in the Group Certificate.

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:

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

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.	See Network Benefits for the services covered.

Not Covered:

- See "Services Not Covered" in the Group Certificate.

TELEMEDICINE SERVICES

Covered Services:

Telemedicine Services are covered under this Benefits Chart, subject to our medical coverage criteria.

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.

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.

Prior authorization is required prior to consultation to support coordination of care and benefits.

Covered Services:

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

- Kidney transplants for end-stage disease.
- Cornea transplants for end-stage disease.
- Heart transplants for end-stage disease.
- 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.
- 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.
- 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.
- 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.
- 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 expenses incurred for directly related donor services, shall be subject to and in accordance with the provisions, limitations, maximums and other terms of this Benefits Chart.

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 modifications by the medical director.

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

Transplant Travel Benefit for Network Benefits

We may provide travel and lodging when an insured needs a transplant and a designated transplant center is greater than 100 miles from the insured’s primary address.

This benefit is subject to our medical policies (medical coverage criteria). Coverage criteria are available by calling Member Services, or logging on to your “*my*HealthPartners” account at healthpartners.com.

When submitting receipts for travel and lodging, the insured will need to attach a letter explaining that the receipts are in conjunction with an authorized organ or bone marrow transplant and include the recipient's name and member ID number or complete a Lodging and Travel Claim form with the receipts.

Network Benefits	**Non-Network Benefits**
Transplant travel benefits are covered under the Network transplant services benefit. Expenses for travel and lodging for the insured (the transplant recipient) and one adult companion, or up to two companions for a transplant recipient who is a minor dependent, may be covered up to a maximum of $10,000 per transplant. Lodging coverage is limited to $100 per day.	No coverage.

Not Covered:

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

Statement of Nondiscrimination for Health Plan Members

Our Responsibilities:
We follow Federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex. We do not exclude people or treat them differently because of their race, color, national origin, age, disability or sex, including gender identity.

- We help people with disabilities to communicate with us. This help is free. It includes:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio and accessible electronic formats
- We provide services for people who do not speak English or who are not comfortable speaking English. These services are free. They include:
  - Qualified interpreters
  - Information written in other languages

For Language or Communication Help:
Call 1-800-883-2177 if you need language or other communication help. (TTY: 711)

If you have questions about our non-discrimination policy:
Contact the Civil Rights Coordinator at 1-844-363-8732 or integrityandcompliance@healthpartners.com.

To File a Grievance:
If you believe that we have not provided these services or have discriminated against you because of your race, color, national origin, age, disability or sex, you can file a grievance by contacting the Civil Rights Coordinator at 1-844-363-8732, integrityandcompliance@healthpartners.com or Civil Rights Coordinator, Office of Integrity and Compliance, MS 21103K, 8170 33rd Ave. S., Bloomington, MN 55425.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
Room 509F, HHH Building
200 Independence Avenue SW, Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Español *(Spanish)* ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-883-2177. (TTY: 711)	ພາສາລາວ *(Laotian)* ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-883-2177. (TTY: 711)
Hmoob *(Hmong)* LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-883-2177. (TTY: 711)	Deutsch *(German)* ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-883-2177. (TTY: 711)
Tiếng Việt *(Vietnamese)* CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-883-2177. (TTY: 711)	العربية *(Arabic)* ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-883-2177 (رقم هاتف الصم والبكم: 711)
繁體中文 *(Chinese)* 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-883-2177. (TTY: 711)	Français *(French)* ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-883-2177. (ATS: 711)
Русский *(Russian)* ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-883-2177. (телетайп: 711)	한국어 *(Korean)* 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-883-2177. (TTY: 711)
Af Soomaali *(Somali)* OGAYSIIS: Haddii aad ku hadasho afka soomaaliga, Waxaa kuu diyaar ah caawimaad xagga luqadda ah oo bilaash ah. Fadlan soo wac 1-800-883-2177. (TTY: 711)	Tagalog *(Tagalog)* PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-883-2177. (TTY: 711)

Additional languages listed on page 2

Oromiffa *(Cushite [Oromo])*
XIYYEEFFANNAA: Afaan dubbattu Oromiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-883-2177. (TTY: 711)

Italiano *(Italian)*
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-883-2177. (TTY: 711)

አማርኛ *(Amharic)*
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-883-2177. (መስማት ለተሳናቸው: 711)

ภาษาไทย *(Thai)*
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-883-2177. (TTY: 711)

unD *(Karen)*
ဟ်သူဉ်ဟ်သး– နမ့ါကတိၤ ကညီ ကျိာ်အယိ, နမၤန့ါ ကျိာ်အတ်မၤစၢၤလၢ တလာ်ဘူဉ်လာ်စ့ၢ နီတမံၤဘဉ်သ့နှဉ်လိၤ. ကိး 1-800-883-2177. (TTY: 711)

ελληνικά *(Greek)*
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-883-2177. (TTY: 711)

ខ្មែរ *(Mon-Khmer, Cambodian)*
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-883-2177. (TTY: 711)

Diné Bizaad *(Navajo)*
Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-883-2177. (TTY: 711)

Deitsch *(Pennsylvanian Dutch)*
Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-883-2177. (TTY: 711)

Ikirundi *(Bantu – Kirundi)*
ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-883-2177. (TTY: 711)

Polski *(Polish)*
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-883-2177. (TTY: 711)

Kiswahili *(Swahili)*
KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-883-2177. (TTY: 711)

हिंदी *(Hindi)*
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-883-2177. (TTY: 711)

日本語 *(Japanese)*
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-883-2177 (TTY: 711) まで、お電話にてご連絡ください。

Shqip *(Albanian)*
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-883-2177. (TTY: 711)

नेपाली *(Nepali)*
ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-883-2177 (टिटिवाइ: 711)

Srpsko-hrvatski *(Serbo-Croatian)*
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-883-2177. (TTY: 711)

Norsk *(Norwegian)*
MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-883-2177. (TTY: 711)

ગુજરાતી *(Gujarati)*
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-883-2177. (TTY: 711)

Adamawa *(Fulfulde, Sudanic)*
MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-883-2177. (TTY: 711)

اُردُو *(Urdu)*
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-883-2177 (TTY: 711).

Українська *(Ukranian)*
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-883-2177. (телетайп: 711)