HealthPartners Insurance Company
Wisconsin Small Employer Plan
Platinum
Benefits Chart

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

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

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

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

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

When you use Non-Network providers, benefits are substantially reduced and you will likely incur significantly higher out-of-pocket expenses. A Non-Network provider does not usually have an agreement with HealthPartners to provide services at a discounted fee. In addition, most Non-Network Benefits are restricted to the usual and customary amount as described under the definition of "Charge". The usual and customary amount can be significantly lower than a Non-Network provider's billed charges. If the Non-Network provider's billed charges are over the usual and customary amount, you pay the difference, in addition to any required deductible, copayment and/or coinsurance, and these charges do not apply to the out-of-pocket limit. The only exceptions to this requirement are described below in the "Emergency and Urgently Needed Care Services" section. This section describes what benefits are covered at the Network Benefit level regardless of who provides the service.

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

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

These definitions apply to this Benefits Chart. They also apply to the 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 a network provider, this is the provider's discounted fee 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 charge for a given service. However, if the network provider's discounted charge for a service or item is less than the flat dollar copayment, you will pay the network provider's discounted charge. An amount which is listed as a percentage of charges or coinsurance is based on the network provider's discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule rate for case rate or withhold arrangements.

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

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

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

Any amounts paid or reimbursed by a third party, including but not limited to: point of service rebates, manufacturer coupons, manufacturer debits 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. 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.

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.

Lifetime Maximum Benefit: The specified coverage limit actually paid by us for services and/or charges incurred by you for any given procedure or diagnosis. Payment of benefits under this Benefits Chart ceases when that lifetime maximum benefit is reached. You have to pay for any subsequent charges.

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

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

Out-of-Pocket Limit: You pay the copayments/coinsurance and deductibles for covered services, to the individual or family out-of-pocket limit. Thereafter we cover 100% of the charges incurred for all other covered services, for the rest of the calendar year. You pay amounts greater than the out-of-pocket limit if you exceed any lifetime maximum benefit or 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 Member Services 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
$500	$10,000

Family Calendar Year Deductible

Network Benefits	Non-Network Benefits
$1,500	$20,000

Separate deductibles 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 debits 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
$3,500	$30,000

Family Calendar Year Out-of-Pocket Limit

Network Benefits	Non-Network Benefits
$7,000	$60,000

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

Non-Network Benefits above the usual and customary charge will not apply to the individual or family Out-of-Pocket Limit.

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

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 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
80% of the charges incurred.	See Network Benefits.

Non-Emergency Fixed Wing Air Ambulance Transportation

Network Benefits	Non-Network Benefits
80% of the charges incurred.	50% of the charges incurred.

Not Covered:

- See "Services Not Covered" in the Certificate.

AUTISM TREATMENT

Covered Services:

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

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

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

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

Intensive-Level Services for children diagnosed with autism spectrum disorders. Intensive-level services must begin on or after two years of age and end before nine years of age. Intensive-level services, on average, are services provided for more than 20 hours of treatment per week. (The average number of hours a week is calculated over a six-month period.)

Network Benefits	Non-Network Benefits
100% of the charges incurred, subject to a copayment of $25 per visit. Deductible does not apply. Limited to 235 visits per calendar year.	50% of the charges incurred. Limited to 235 visits per calendar year.

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

Intensive-Level Services Lifetime Maximum Benefit

Network Benefits	Non-Network Benefits
4 years of cumulative services under this plan or any other plan.	4 years of cumulative services under this plan or any other plan.

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

Nonintensive-Level Services for Insureds diagnosed with autism spectrum disorders

Network Benefits	Non-Network Benefits
100% of the charges incurred, subject to a copayment of $25 per visit. Deductible does not apply. Limited to 120 visits per calendar year.	50% of the charges incurred. Limited to 120 visits per calendar year.

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

Not Covered:

- See "Services Not Covered" in the 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.

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

- Mental health services for covered adults in a day treatment program.
- Mental health services for covered children in a day hospital treatment program.
- Services for persons with chronic mental illness provided through a community support program.
- Residential treatment programs for alcohol and/or drug dependent covered persons.
- Alcohol and Other Drug Abuse (AODA) services in, a day treatment program.
- Services for persons who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided.
- Intensive outpatient programs for the treatment of psychoactive substance use disorders provided in accordance with the patient placement criteria of the American Society of Addiction Medicine.

Mental Health Services

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

We provide coverage for mental health treatment ordered by a Wisconsin court under a valid court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. We must be given a copy of the court order and the behavioral care evaluation, and the service must be a covered benefit under this plan, and the service must be provided by a network provider, or other provider as required by law.

Outpatient Services: We cover medically necessary outpatient professional mental health services for evaluation, crisis intervention, and treatment of mental health disorders.

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

Outpatient services we cover for a diagnosed mental health condition include the following:

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

Network Benefits	**Non-Network Benefits**
100% of the charges incurred, subject to a copayment of $25 per visit. 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 a copayment of $12.50 per visit. Deductible does not apply.	50% of the charges incurred.

Inpatient Services: We cover medically necessary inpatient services in a hospital or licensed residential treatment facility and professional services for treatment of mental health disorders. Medical stabilization is covered under inpatient hospital services in the "Hospital and Skilled Nursing Facility Services" section.

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

Network Benefits	**Non-Network Benefits**
80% of the charges incurred.	50% of the charges incurred.

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

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

Substance Abuse Treatment Services

We cover medically necessary services for assessments by a licensed alcohol and drug counselor and treatment of Substance Related Disorders as defined in the latest edition of the DSM 5.

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

- Individual, group, family, and multi-family therapy provided in an office setting.
- We cover opiate replacement therapy including methadone and buprenorphine treatment.

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

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

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

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

Network Benefits	**Non-Network Benefits**
80% of the charges incurred.	50% of the charges incurred.

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

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

Additional Mental Health and Substance Abuse Treatment Benefits for a Dependent Child Who is a Student: If a dependent child is a student in a school and that school is located in Wisconsin, but outside of our service area, we cover services as required under Wisconsin Statute 609.655.

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

Not Covered:

- See "Services Not Covered" in the Certificate.

CHIROPRACTIC SERVICES

Covered Services:

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

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

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

Not Covered:

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

CLINICAL TRIALS

Covered Services:

We cover certain routine services if you participate in a Phase I, Phase II, Phase III or Phase IV approved clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition as defined in the Affordable Care Act. Approved clinical trials include (1) federally funded trials when the study or investigation is approved or funded by any of the federal agencies defined in the Public Health Services Act, section 2709 (d) (1) (A); (2) the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; and (3) the study or investigation is a drug trial that is exempt from having such an investigational new drug application. We cover routine patient costs for services that would be eligible under the Certificate and 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 or experimental item, device or service itself.
- Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- See "Services Not Covered" in the Certificate.

DENTAL SERVICES

Covered Services:

We cover services as described below.

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

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

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

Network Benefits	Non-Network Benefits
80% of the charges incurred.	50% of the charges incurred.

For all accidental dental services, treatment and/or restoration must be initiated within six months of the date of the injury. Coverage is limited to the initial course of treatment and/or initial restoration. Services must be provided within 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 a copayment of $25 per visit. Deductible does not apply.	50% of the charges incurred.

Medically Necessary Hospitalization and Anesthesia for Dental Care: We cover medically necessary hospitalization for dental care. This is limited to charges incurred by an Insured who: (1) is a child under age 5; (2) is severely disabled; (3) has a medical condition, and requires hospitalization or general anesthesia for dental care treatment; or (4) is a child between ages 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. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist professional fees are not covered. The following are examples, though not all-inclusive, of medical conditions which may require hospitalization for dental services: severe asthma, severe airway obstruction or hemophilia. Hospitalization required due to the behavior of the Insured or due to the extent of the dental procedure is not covered.

Network Benefits	Non-Network Benefits
80% 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 a copayment of $25 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 a copayment of $25 per visit. Deductible does not apply.	50% of the charges incurred.

Treatment of Cleft Lip and Cleft Palate: We cover treatment of cleft lip and cleft palate of a dependent child, including orthodontic treatment and oral surgery directly related to the cleft. Dental services which are not required for the treatment of cleft lip or cleft palate are not covered. If a dependent child covered under the Certificate and Benefits Chart is also covered under a dental plan which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same copayment, conditions and limitations as durable medical equipment.

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

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

Network Benefits	Non-Network Benefits
100% of the charges incurred, subject to a copayment of $25 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.
- Orthognathic treatment or procedures and all related services.
- See “Services Not Covered” in the 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
80% 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
80% 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 Certificate.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

Covered Services:

We cover equipment and services, as described below.

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

We cover external hearing aids, cochlear implants, and related treatment prescribed by a physician or by a licensed audiologist for Insureds under 18 years of age who have hearing loss.

We also cover basic hearing aids for Insureds age 18 or older for the correction of a hearing impairment.

Osseointegrated or bone-anchored hearing aids are only covered for Insureds who have hearing loss that is not correctable by any other procedure.

Hearing aids are limited to one basic, standard hearing aid for each ear every three years.

A basic hearing aid is defined as a hearing device that consists of a microphone, amplifier, volume control, battery and receiver, which is up to date using the latest technology. It does not include upgrades above and beyond the functionality of a basic hearing aid, including, but not limited to, hearing improvements for group settings, background noise, Bluetooth/remote control functionality, or extended warranties. Charges for upgrades above the cost of a basic, standard hearing aid are not covered.

Diabetic Supplies Purchased at a Pharmacy

Network Benefits	Non-Network Benefits
80% 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
80% of the charges incurred if purchased from an approved vendor.	50% of the charges incurred.

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

Network Benefits	Non-Network Benefits
80% 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
80% of the charges incurred.	50% of the charges incurred.

All Other Durable Medical Equipment, Prosthetics, Orthotics and Supplies

Network Benefits	Non-Network Benefits
80% of the charges incurred.	50% of the charges incurred.

Limitations:

Coverage of durable medical equipment is limited by the following:

- No more than a 93-day supply of diabetic supplies are covered and dispensed at a time.
- Payment will not exceed the cost of an alternate piece of equipment or service that is effective and medically necessary.
- For prosthetic benefits, other than oral appliances for cleft lip and cleft palate, payment will not exceed the cost of an alternate piece of equipment or service that is effective, medically necessary and enables Insureds to conduct standard activities of daily living.
- We reserve the right to determine if an item will be approved for rental vs. purchase.
- 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 or repaired by approved vendors.
- Covered services and supplies are based on established medical policies which are subject to periodic review and modification by the medical or dental directors. Our medical policy for diabetic supplies includes information on our required models and brands. These medical policies (medical coverage criteria) are available by calling Member Services, or logging on to your "*my*HealthPartners" account at 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.

- Implantable and osseointegrated or bone-anchored hearing aids and their fitting, except as specifically described in this Benefits Chart. This exclusion does not apply to cochlear implants.
- Eyeglasses, contact lenses and their fitting, measurement and adjustment, except as specifically described in this Benefits Chart.
- Hair prostheses (wigs).
- 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, 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 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 the Certificate.

Urgently Needed Care. These are services to treat an unforeseen illness or injury that:

- are required in order to prevent a serious deterioration in your health; and
- cannot be delayed until the next available clinic or office hours.

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

Emergency Care. These are services to treat:

- the sudden, unexpected onset of illness or injury which, if left untreated or unattended until the next available clinic or office hours, would result in hospitalization; or
- a condition requiring professional health services immediately necessary to preserve life or stabilize health.

When reviewing claims for coverage of emergency services, our medical director will take into consideration a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next working day or next available clinic appointment.

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

Network Benefits	**Non-Network Benefits**
80% of the charges incurred.	See Network Benefits.

Inpatient Emergency Care in a Hospital

Network Benefits	**Non-Network Benefits**
80% of the charges incurred.	See Network Benefits.

Not Covered:

- See "Services Not Covered" in the Certificate.

GENE THERAPY

Covered Services:

We cover gene therapy treatment if it meets 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.	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 Certificate.

HEALTH EDUCATION

Covered Services:

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

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

Not Covered:

- See "Services Not Covered" in the Certificate.

HOME-BASED HEALTH ASSESSMENT PROGRAM

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 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.

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

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

Home health services are eligible and covered only when:

- medically necessary; and
- provided as rehabilitative 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 a copayment of $25 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 up to 24-hour visits) equals one visit and counts toward the Maximum visits for all other services shown below. Any visit that lasts less than 24 hours regardless of the length of the visit, will count as one visit toward the Maximum visits for all other services shown below. All visits must be medically necessary and benefit eligible.

Routine Prenatal/Postnatal Services and Child Health Supervision Services

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 Services Other Than Palliative Care

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

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

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

Not Covered:

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

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Network Benefits	Non-Network Benefits
80% of the charges incurred.	50% of the charges incurred.

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

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

Outpatient services include: use of operating rooms, maternity delivery rooms or other outpatient departments, rooms or facilities; and the following outpatient services: general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, drugs administered during treatment, blood and blood products (unless replaced), and blood derivatives, and other diagnostic or treatment related outpatient services; physician and other professional medical and surgical services provided while an outpatient, including colonoscopies (starting at age 50, or under age 50 for people at high risk of colorectal cancer), and gender reassignment surgery that meets medical coverage criteria.

For Network Benefits, non-emergent, scheduled outpatient Magnetic Resonance Imaging (MRI) and 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**
80% 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. Rehabilitation services are limited to services where significant measurable progress is expected to occur within a reasonable period of time.

Network Benefits	**Non-Network Benefits**
80% of the charges incurred. Limited to a 30 day maximum per confinement.	50% of the charges incurred. Limited to a 30 day maximum per confinement.

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

Not Covered:

- Services for items for personal convenience, such as television rental, are not covered.
- See “Services Not Covered” in the 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**
80% of the charges incurred. Deductible does not apply.	50% of the charges incurred.

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, 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 cover office visits and consultations to diagnose infertility.
- Services related to the establishment of surrogate pregnancy and fees for a surrogate.
- See “Services Not Covered” in the Certificate.

LABORATORY SERVICES

Covered Services:

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

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

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 Certificate.

MASTECTOMY RECONSTRUCTION BENEFIT

Covered Services:

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

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

Not Covered:

- See "Services Not Covered" in the 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 Network pharmacist.

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

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

Not Covered:

- See "Services Not Covered" in the 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 eye glass lenses are prescribed as medically necessary for the post-operative treatment of cataracts or for the treatment of aphakia, or keratoconus, we cover the initial evaluation, lenses and fitting. Insureds must pay for lens replacement beyond the initial pair.

Office Visits

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

Convenience Clinics

Network Benefits	Non-Network Benefits
100% of the charges incurred, subject to a copayment of $10 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 a copayment of $10 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 a copayment of $10 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 a 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 a 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. Any resulting court ordered treatment for mental health services will be subject to the Certificate's requirement for medical necessity.
- See "Services Not Covered" in the Certificate.

PEDIATRIC EYEWEAR

Covered Services:

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

Network Benefits	Non-Network Benefits
80% of the charges incurred.	No coverage.

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

Not Covered:

- See "Services Not Covered" in the Certificate.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY AND OTHER SPECIFIED THERAPIES

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. 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 a copayment of $25 per visit. Deductible does not apply. Physical, Occupational and Speech Therapy are limited to 20 visits each per calendar year.	50% of the charges incurred. Physical, Occupational and Speech Therapy are limited to 20 visits each per calendar year.

In addition to the services provided above, we cover a minimum of:

- 20 visits per calendar year for pulmonary rehabilitation therapy.
- 36 visits per calendar year for cardiac rehabilitation therapy.
- 30 visits per calendar year for post-cochlear implant aural therapy.
- 20 visits per calendar year for cognitive rehabilitation therapy.

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

Habilitative Services

Network Benefits	**Non-Network Benefits**
100% of the charges incurred, subject to a copayment of $25 per visit. Deductible does not apply. Physical, Occupational and Speech Therapy are limited to 20 visits each per calendar year.	50% of the charges incurred. Physical, Occupational and Speech Therapy are limited to 20 visits each per calendar year.

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

Not Covered:

- Massage therapy for the purpose of comfort or convenience of the Insured.
- See "Services Not Covered" in the 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 will refill a prescription for eye drops covered under this Benefits Chart if the Insured requests a refill and the 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 22 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 67 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.

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 a copayment of $5 for generic low cost formulary drugs and 100% of the charges incurred, subject to a copayment of $25 for generic high cost formulary drugs. Brand name formulary drugs are covered at 100% of the charges incurred, subject to a copayment of $60. 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 a copayment of $150. Deductible does not apply.	50% of the charges incurred.

Oral chemotherapy drugs are included on the Specialty Drug List. However, you pay the applicable outpatient drug copayment. As required by Wisconsin law, your maximum copayment will not be more than $100 per prescription for a 31-day supply.

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

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

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.

Specialty Drugs which are Self-Administered

Network Benefits	Non-Network Benefits
80% of the charges incurred. Deductible does not apply. Specialty Drugs are limited to drugs on the Specialty Drug List and must be obtained from a designated vendor.	No coverage.

Oral chemotherapy drugs are included on the Specialty Drug List. However, you pay the applicable outpatient drug copayment. As required by Wisconsin law, your maximum copayment will not be more than $100 per prescription for a 31-day supply.

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.
- 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.
- A 93-day supply will be covered and dispensed only at pharmacies that participate in our extended day supply program.
- New prescriptions to treat certain chronic conditions are limited to a 31-day supply.
- No more than a 31-day supply of specialty drugs will be covered and dispensed at a time unless it's a manufacturer supplied drug that cannot be split that supplies the member 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. This exclusion does not include over-the-counter contraceptives for women as allowed under the Affordable Care Act when the Insured obtains a prescription for the item. In addition, if the Insured obtains a prescription, this exclusion does not include aspirin to prevent cardiovascular disease for men and women of certain ages; folic acid supplements for women who may become pregnant; fluoride chemoprevention supplements for children without fluoride in their water source; and iron supplements for children age 6-12 who are at risk for anemia.
- All drugs for the treatment of sexual dysfunction.
- All drugs for the treatment of growth deficiency.
- All drugs 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.
- 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 Certificate.

PREVENTIVE SERVICES

Applicable Definitions:

Routine Preventive Services are routine health care 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 otherwise 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, 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 and counseling for tobacco cessation and all FDA approved tobacco cessation medications including over-the-counter drugs (as shown in the Prescription Drug Services section).

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 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.

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

Routine Prenatal Care and Exams

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 starting at age 50 and under age 50 for people at high risk of colorectal cancer. This also includes cancer screenings recommended by the USPSTF with an A or B rating. Women's preventive health services below describe 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.	50% of the charges incurred.

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, counseling and screening for human immunodeficiency virus (HIV), and all FDA approved contraceptive methods as prescribed by a doctor, sterilization procedures, education and counseling (see the Prescription Drug Services section for coverage of oral contraceptive drugs). We also provide genetic screening for BRCA if someone in your family has the gene or you have a diagnosis of cancer.

The U.S. Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older. For women age 50 and older, we cover an annual mammogram.

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 Test 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 test for ovarian cancer" means annual screening using CA-125 serum tumor marker testing, transvaginal ultrasound, pelvic examination or other proven ovarian 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 Benefits, depending on type of service provided, such as Diagnostic Imaging Services, Laboratory Services or Office Visits for Illness or Injury, or Preventive Services.	Coverage level is same as corresponding Non-Network Benefits, depending on type of service provided, such as Diagnostic Imaging Services, Laboratory Services or 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 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.

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 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).

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 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 the Certificate.

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

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

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

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

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

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 that 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 or experimental and do not cover them: surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, non-human organ implants and/or transplants and other transplants not specifically listed in the Certificate.
- See "Services Not Covered" in the Certificate.