HealthPartners Insurance Company
Benefits Chart

Group Name: Roseville Area Schools ISD 623 dba Roseville Area Schools 623

Group Number: 0311

Effective Date: The later of July 1, 2024 and your effective date of coverage under the Group Policy.

UNDERSTANDING YOUR COVERAGE

This Benefits Chart is the part of the Group Certificate (Certificate) that explains how much you will pay for Medically Necessary services.

Covered Services are based on the conditions, limitations and exclusions in this Benefits Chart, other sections of the Certificate, our Medical Policies and your drug Formulary.

Our Medical Policies (Coverage Criteria Policies) list specific criteria that must be met for certain supplies, Health Care Services, behavioral health services and procedures to be considered Medically Necessary. A Formulary is a list of drugs and how they are covered. Both Coverage Criteria Policies and the Formulary contain information about Prior Authorization requirements. Your Network Provider will facilitate the Prior Authorization process for you when needed.

We review and update Coverage Criteria Policies and Formularies regularly. To learn more about our Coverage Criteria Policies or your Formulary, log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services.

Benefits are underwritten by HealthPartners Insurance Company.

HOW TO USE THIS BENEFITS CHART

This Benefits Chart is divided into sections based on different types of care or services. Each section includes the amount or percentage we pay for Covered Services when received from Network and Out-of-Network Providers. When needed, sections will also include specific limitations or conditions for that coverage. You are responsible for the specified Copayment amount and/or percentage of Charges that we do not pay.

You are also responsible for all Charges related to any non-covered services. Please refer to any "Not Covered" lists in each benefit category as well as the "Services Not Covered" section to better understand your coverage.

Certain capitalized words have special meanings. We define these words in "General Definitions" or within applicable benefit categories. Additional capitalized terms are defined in the Certificate.

HOW YOUR CHOICE OF PROVIDERS AFFECTS YOUR COVERAGE

You have direct access to any Network Providers listed in your Provider directory.

How much you pay for Covered Services may vary depending on whether you select a Network Provider or an Out-of-Network Provider.

For most non-emergency services, your benefits could be greatly reduced when you use Out-of-Network Providers. This means you will have to pay more in Out-of-Pocket Expenses. Most Out-of-Network Providers do not have a contract with us to provide services at a discounted rate.

For Covered Services delivered by Out-of-Network Providers that do not have a contract with us, we will only pay up to the usual and customary charge. This is explained in more detail in the definition of "Charge". The usual and customary Charge can be significantly lower than an Out-of-Network Provider's billed Charges. If the Out-of-Network Provider's billed Charges are over the usual and customary charge, you pay the difference. You also pay any required Deductible, Copayment and/or Coinsurance. Charges above the usual and customary charge do not apply to the Deductible or Out-of-Pocket Limit.

The No Surprises Act prohibits "Surprise" Billing (also known as "balance" billing) in most circumstances. For the following services, your benefits are not reduced when you use Out-of-Network Providers: air ambulance, emergency care, certain post-stabilization care and certain non-emergency services from Out-of-Network Providers at certain Network Facilities. Provisions of the No Surprises Act do not apply to Out-of-Network claims from Providers that are outside of the US or US territories. Coverage level for services received outside of these areas is the same as corresponding Out-of-Network Benefits, depending on the type of service provided. Additional information regarding coverage under the No Surprises Act is described in the "Rights and Protections Under the No Surprises Act" section of the Certificate.

For questions about coverage, contact Member Services at the number on the back of your ID card.

GENERAL DEFINITIONS

These definitions apply to this Benefits Chart. They also apply to the Certificate.

Charge. For Covered Services delivered by participating Network Providers or Out-of-Network Providers that have a contract with us, this is the Provider's contracted rate for a given service, procedure or item.

For Covered Services delivered by Out-of-Network Providers that do not have a contract with us, this is the usual and customary charge.

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 may be liable for any charges above the usual and customary charge, and they do not apply to the Deductible or Out-of-Pocket Limit.

The usual and customary charge is determined using one of the following options in the following order, depending on availability: 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.

A charge is incurred for covered Outpatient surgical and non-surgical services and for Inpatient professional and Physician fees on the date the service or item is provided. A charge is incurred for covered Inpatient Facility fees on the date of Admission to a Hospital and will be covered at the benefit in place on the date of Admission for the duration of your Hospital stay. To be covered, a charge must be incurred on or after your effective date and on or before the termination date.

Clinically Accepted Medical Services. These are techniques or services that have been determined to be effective for general use, based on risk and medical implications. Some clinically accepted techniques are approved only for limited use, under specific circumstances.

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 an Out-of-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.

Cosmetic Surgery. This is surgery to improve or change appearance (other than Reconstructive Surgery), which is not necessary to treat a related Illness or Injury.

Covered Service. This is a specific medical or dental service or item, which is Medically Necessary and covered by us, as described in this Benefits Chart.

Custodial Care. These are supportive services focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including, but not limited to, bathing, dressing and feeding.

Deductible. The specified dollar amount of Charges incurred for Covered Services, which we do not pay, but an Insured or a family has to pay first in a Plan 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 Out-of-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 the 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.

Deductible Carryover. Charges incurred in the last three months of a Plan Year, which are applied to any Deductible for that Plan Year, are carried over and applied toward any Deductible for the following Plan Year. The deductible carryover amount does not apply to the Out-of-Pocket Limit for the following Plan Year.

Illness. This is a sickness or disease, including all related conditions and recurrences, requiring Medically Necessary treatment.

Injury. This is an accident to the body, requiring medical treatment.

Investigative. As determined by us, a drug, device, medical, behavioral health or dental treatment is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or positive effect on health outcomes and will be considered investigative unless all of the following categories of reliable evidence are met:

- There is final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the United States Food and Drug Administration (FDA); and
- The drug or device or medical, behavioral health or dental treatment or procedure is not the subject of ongoing Phase I, II or III clinical trials; and
- The drug, device or medical, behavioral health or dental treatment or procedure is not under study and further studies are not needed (such as post-marketing clinical trial requirements) to determine maximum tolerated dose, toxicity, safety, effect on health outcomes or efficacy as compared to existing standard means of treatment or diagnosis; and
- There is conclusive evidence in major peer-reviewed medical journals demonstrating the safety, effectiveness and positive effect on health outcomes (the beneficial effects outweigh any harmful effects) of the service or treatment when compared to standard established service or treatment. Each article must be of well-designed investigations, using generally acceptable scientific standards that have been produced by nonaffiliated, authoritative sources with measurable results. Case reports do not satisfy this criterion. This also includes consideration of whether a drug is included in one of the standard reference compendia or "Major Peer Reviewed Medical Literature" (defined below) for use in the determination of a Medically Necessary accepted indication of drugs and biologicals used off-label as appropriate for its proposed use.

  Major Peer Reviewed Medical Literature. This means articles from major peer reviewed medical journals that have recognized the drug or combination of drugs' safety and effectiveness for treatment of the indication for which it has been prescribed. Each article shall meet the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or be published in a journal specified by the United States Secretary of Health and Human Services pursuant to United States Code, title 42, section 1395x, paragraph (t), clause (2), item (B), as amended, as acceptable peer review medical literature. Each article must use generally acceptable scientific standards and must not use case reports to satisfy this criterion.

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.

Maintenance Care. These are supportive services, including skilled or non-skilled nursing or therapy care, to assist you when your condition has not improved or has deteriorated significantly over a measurable period of time (generally a period of two months). Care may be determined to be maintenance care, regardless of whether your condition requires skilled medical care or the use of medical equipment. This definition does not apply to mental health or substance use disorder treatment services.

Medically Necessary Care. These are Health Care Services appropriate, in terms of type, frequency, level, setting, and duration, to the Insured's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by Health Care Providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must help restore or maintain your health or prevent deterioration of your condition.

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 Plan Year. You pay amounts greater than the out-of-pocket limit if you exceed any Lifetime Maximum Benefit or visit or day limits.

Out-of-Network Benefits above the usual and customary charge (see definition of Charge in this "General Definitions" section) do not apply to the out-of-pocket limit.

Out-of-Network Benefits for transplant surgery and bariatric 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 Insured 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.

Over-the-Counter (OTC). These are items, medical equipment, or medicines available without a prescription.

Plan Year. Applies to provisions which are based on a plan year. The initial plan year begins at 12:01 A.M. Central Time on the effective date of the Group Health Plan Sponsor's Group Policy and ends at 12:00 A.M. of the first anniversary date. Subsequent plan years begin at 12:01 A.M. of the anniversary date and end at 12:00 A.M. of the following anniversary date.

Prior Authorization. This means a determination by our medical or dental directors, or their designees, that an Admission, extension of stay, or other Health Care Service has been reviewed and that, based on the information provided, it satisfies our utilization review requirements. We will then pay for the covered benefit, provided the general exclusion provisions, and any Deductible, Copayment, Coinsurance, or other requirements have been met.

DEDUCTIBLES AND OUT-OF-POCKET LIMITS

Individual Plan Year Deductible

Network Benefits	Out-of-Network Benefits
None.	$200

Family Plan Year Deductible

Network Benefits	Out-of-Network Benefits
None.	$600

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 the Deductible, to the extent permitted under state and federal law.

Individual Plan Year Out-of-Pocket Limit

Network Benefits	Out-of-Network Benefits
$750	$1,000

Family Plan Year Out-of-Pocket Limit

Network Benefits	Out-of-Network Benefits
$1,500	$2,000

The Out-of-Pocket Limits under the Network Benefits and the Out-of-Network Benefits are combined.

Out-of-Network Benefits above the usual and customary charge will not apply toward the individual or family Out-of-Pocket Limit. See the definition of Charge in the “General Definitions” section.

Out-of-Network Benefits for transplant surgery and bariatric 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.

YOUR BENEFITS

We provide coverage for the following services based on the conditions, limitations and exclusions in this Benefits Chart, other sections of the Certificate, our Coverage Criteria Policies and your Drug Formulary. Please refer to any "Limitations" and "Not Covered" lists within individual benefit categories as well as the "Services Not Covered" section to better understand the coverage available to you.

ACUPUNCTURE

Covered Services:

We cover acupuncture services when Medically Necessary.

Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $35 per visit.	80% of the Charges incurred.

AMBULANCE AND MEDICAL TRANSPORTATION

Covered Services:

We cover ground ambulance, fixed wing air ambulance and rotary wing air ambulance for medical emergencies.

We also cover ground ambulance, fixed wing air ambulance and rotary wing air ambulance for non-emergency medical transportation if it meets our Coverage Criteria Policies.

Non-emergency fixed wing air ambulance requires Prior Authorization.

Under the No Surprises Act, Out-of-Network air ambulance Providers may not bill patients for more than their cost-sharing responsibility for the corresponding Network service.

Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	See Network Benefits. The amount you pay for air ambulance services will be determined based on the requirements of the No Surprises Act and its implementing regulations.

AUTISM SERVICES

Covered Services:

For children age 17 or younger, we cover the diagnosis, evaluation, and multidisciplinary assessment of autism spectrum disorders. In addition to other services that may be used to treat autism spectrum disorders addressed elsewhere in this Benefits Chart, we cover Medically Necessary Care including, but not limited to, the following:

- Early intensive behavioral and developmental therapy based in behavioral and developmental science, including, but not limited to, all types of applied behavior analysis, intensive early intervention behavior therapy and intensive behavior intervention
- Neurodevelopmental and behavioral health treatments and management

Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

Physical therapy, occupational therapy and speech therapy are covered under the "Physical Therapy, Occupational Therapy and Speech Therapy" section. Medications are covered under the "Prescription Drugs" section.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $35 per visit.	80% of the Charges incurred.

BEHAVIORAL HEALTH SERVICES

Definitions:

Mental Health Professional. This is a psychiatrist, psychologist, or mental health therapist licensed for independent practice, lawfully performing a mental health or substance use disorder service in accordance with governmental licensing privileges and limitations, who renders mental health or substance use disorder services, as covered in this Benefits Chart.

Residential Behavioral Health Treatment Facility. This is a facility licensed under state law for the treatment of mental health or substance use disorders and that provides Inpatient treatment of those conditions by, or under the direction of, a Physician. The Facility provides continuous, 24-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day. A residential behavioral health treatment facility does not, other than incidentally, provide educational or recreational services as part of its treatment program.

Covered Services:

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 use disorder services be covered on the same basis as medical services
- That cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services
- That treatment restrictions and limitations such as Prior Authorization and Medical Necessity can be no more restrictive than for similar medical services
- That if Insureds 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). Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

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; 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 used 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 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
- Treatment for gender dysphoria

Services received via video, E-visits or telephone are covered under the "Telehealth/Telemedicine Services" section.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $35 per visit. For family therapy, only one Copayment will be charged, regardless of the number of Insureds primarily involved in the therapy.	80% of the Charges incurred.

Group therapy

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $17.50 per visit.	80% of the Charges incurred.

Inpatient services, including mental health residential treatment services. We cover the following:

- 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.
- Medically Necessary mental health residential treatment services. This includes the treatment of emotionally disabled Children. This care must be authorized by us and provided by a Hospital or Residential Behavioral Health Treatment Facility licensed by the local state or Department of Health and Human Services. Services not covered under this benefit include halfway houses, group homes, extended care Facilities, shelter services, correctional services, detention services, transitional services, housing support programs, foster care services and wilderness and outdoor programs.

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% of the Charges incurred.

Substance use disorder (SUD) services

We cover Medically Necessary services for assessments by a licensed alcohol and drug counselor and treatment of substance use disorders as defined in the latest edition of the DSM-5. Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

Outpatient services, including intensive Outpatient and day treatment services. We cover Medically Necessary Outpatient professional services for the diagnosis and treatment of substance use disorder. Substance use disorder treatment services must be provided by a program licensed by the local Department of Health and Human Services.

Outpatient services we cover for a diagnosed substance use disorder include the following:

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

- Substance use disorder treatment provided to an Insured by the Department of Corrections while the Insured is committed to the custody of the commissioner of corrections following a conviction for a first-degree driving while impaired offense if:
  - A court of competent jurisdiction makes a preliminary determination based on a chemical use assessment conducted under section 169A.70 that treatment may be appropriate and includes this determination as part of the sentencing order; and
  - The Department of Corrections makes a determination based on a chemical assessment conducted while the individual is in the custody of the department that treatment is appropriate

Treatment provided by the Department of Corrections that meets the requirements of this section shall not be subject to a separate Medical Necessity determination under our utilization review procedures.

Network Benefits	**Out-of-Network Benefits**
100% of the Charges incurred, subject to your Copayment of $35 per visit. For family therapy, only one Copayment will be charged, regardless of the number of Insureds primarily involved in the therapy.	80% of the Charges incurred.

Inpatient services. We cover the following:

- Medically Necessary Inpatient services in a Hospital or primary residential treatment in a licensed substance use disorder treatment center. Primary residential treatment is an intensive residential treatment program of limited duration, typically 30 days or less.
- Services provided in a Hospital that is licensed by the local state and accredited by Medicare
- Detoxification services in a Hospital or community detoxification Facility if it is licensed by the local Department of Health and Human Services

Network Benefits	**Out-of-Network Benefits**
90% of the Charges incurred.	80% of the Charges incurred.

Not Covered:

- Court-ordered mental health treatment, except as described above
- Halfway houses, group homes, extended care Facilities, shelter services, transitional services, housing support programs, foster care services, housing stabilization and low intensity residential treatment for substance use disorders
- Correctional services and detention services
- Wilderness and outdoor programs even when the program is through a licensed Facility
- Animal therapy, including hippotherapy and equine therapy
- Conversion therapy, which is any practice by a mental health practitioner or Mental Health Professional that seeks to change a person's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward people regardless of gender. Conversion therapy does not include counseling that provides assistance to a person undergoing gender transition. It also does not include counseling that provides acceptance, support and understanding of a person or facilitates a person's coping, social support and identity exploration and development, including sexual-orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as the counseling does not seek to change the person's sexual orientation or gender identity.
- Religious counseling
- Marital/relationship counseling
- Sex therapy
- Professional services associated with substance use disorder interventions. A "substance use disorder intervention" is a gathering of family and/or friends to encourage an Insured to seek substance use disorder treatment.

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

Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $35 per visit.	80% of the Charges incurred. Limit of 20 visits per Plan Year.

Not Covered:

- Massage therapy, except as described above

CLINICAL TRIALS

Covered Services:

We cover certain routine services if you participate in a Phase I, II, III or 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 or Minnesota Statute 62Q.526. We cover routine patient costs for services that would be eligible under this Benefits Chart if the services were provided outside of a clinical trial.

Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

Network Benefits	Out-of-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 Out-of-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

DENTAL SERVICES

Covered Services:

We cover services described below. Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

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.

Dentally necessary care is limited to diagnostic testing, treatment and the use of dental equipment and appliances which in the judgement of a dentist is required to prevent deterioration of dental health, or restore dental function. Your general health must permit the necessary procedure(s).

Coverage is for damage caused by external trauma to face and mouth only, not for cracked or broken teeth which result from biting, chewing, clenching or grinding of teeth. 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. Implants must be Prior Authorized and provided by a Network Provider.

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% 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, including anesthesia. 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	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $35 per visit.	80% of the Charges incurred.

Medically Necessary hospitalization and anesthesia for dental care. We cover Facility-related Charges and anesthesia expenses associated with dental care completed in a Hospital, Outpatient Hospital or ambulatory surgery center for:

- Children age 4 or younger
- Pediatric dental patients when 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
- Insureds who are severely psychologically impaired or developmentally disabled, regardless of age
- Insureds who have a serious underlying medical condition, regardless of age, for whom dental treatment would create significant or undue medical risk if not completed in a Hospital or ambulatory surgery center
- Extensive procedures which prevent an oral surgeon from providing general anesthesia in the office, regardless of age

Anesthesia is covered in a Hospital or a 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.

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.

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% of the Charges incurred.

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	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $35 per visit.	80% of the Charges incurred.

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	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $35 per visit.	80% of the Charges incurred.

Orthognathic surgery. We cover orthognathic surgery for the treatment of severe skeletal dysmorphia where a functional occlusion cannot be achieved through non-surgical treatment alone and where a demonstrable functional impairment exists. Functional impairments include, but are not limited to, significant impairment in chewing, breathing or swallowing. Associated dental or orthodontic services (pre- or postoperatively including surgical rapid palatal expansion) are not covered as part of this benefit.

Network Benefits	Out-of-Network Benefits
80% of the Charges incurred.	80% of the Charges incurred.

Treatment of cleft lip and cleft palate of a Dependent Child. Coverage is limited to the age included in the definition of an "Eligible Dependent", 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 Coinsurance, conditions and limitations as durable medical equipment.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $35 per visit.	80% of the Charges incurred.

Treatment of temporomandibular disorder (TMD) and craniomandibular disorder (CMD). We cover diagnostic procedures, surgical treatment and non-surgical treatment for TMD and CMD. Services must be Medically Necessary 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	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $35 per visit.	80% of the Charges incurred.

Not Covered:

- Dental treatment, procedures or services not described above
- Accident-related dental services when any of the following is true about your treatment:
  - Provided to teeth which are not: sound, natural and unrestored
  - Initiated beyond six months from the date of the Injury
  - Received beyond the initial treatment or restoration
  - Received beyond 24 months from the date of Injury
- Oral surgery to remove wisdom teeth

DIABETES AND HYPERTENSION DISEASE MANAGEMENT PROGRAM

Covered Services:

A Diabetes and/or Hypertension Disease Management Program is available through Omada Health for eligible Insureds with diabetes and/or high blood pressure. The program uses connected devices and a health coach to create lasting behavior changes by focusing on weight loss, exercise, behavior modification and health education.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred.	Not applicable.

DIABETIC EQUIPMENT AND SUPPLIES

Covered Services:

We cover Physician-prescribed, medically appropriate and necessary drugs and supplies used in the management and treatment of diabetes for Insureds with gestational, Type I or Type II diabetes, including durable diabetic equipment and disposable supplies, as described below. Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

Insulin and medications for diabetes are covered as Outpatient drugs under the "Prescription Drugs" section.

Pumps and pump supplies. These include diabetic insulin pumps, diabetic infusion pumps and infusion pump supplies such as infusion sets, tubing, connectors and syringe reservoirs.

Network Benefits	Out-of-Network Benefits
Pumps received through a pharmacy: 90% of the Charges incurred. **Pumps received through a non-pharmacy Provider:** 90% of the Charges incurred if purchased from an approved vendor.	80% of the Charges incurred.

All other diabetic durable equipment and supplies

Durable diabetic equipment and supplies. These include continuous glucose monitoring system (CGMS), transmitter, sensors and receivers, diabetic blood glucose monitors and control/calibrating solutions (for checking accuracy or testing equipment and test strips).

Disposable diabetic supplies. These are one-time use supplies, including syringes, lancets, lancet devices, blood and urine ketone test strips, and needles.

Network Benefits	Out-of-Network Benefits
If received through a pharmacy: 90% of the Charges incurred. **If received through a non-pharmacy Provider:** 90% of the Charges incurred if purchased from an approved vendor.	80% of the Charges incurred.

Limitations:

- No more than a 90-day supply of diabetic supplies is covered and dispensed at a time
- Diabetic supplies and equipment are limited to certain models and brands. Our Commercial Diabetic Drug List includes information on required models and brands.
- Durable medical equipment and supplies must be obtained from or repaired by approved vendors
- Certain diabetic supplies and equipment must be purchased at a pharmacy

Not Covered:

- Replacement or repair of any covered items, if the items are damaged or destroyed by misuse, abuse or carelessness, lost or 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
- Batteries for monitors and equipment
- Sales tax, mailing, delivery charges, service call charges

DIAGNOSTIC IMAGING SERVICES

Covered Services:

This benefit applies to diagnostic imaging ordered by a Provider and received in a clinic or Outpatient Hospital Facility.

Diagnostic imaging services received during an Inpatient Hospital or Skilled Nursing Facility stay are covered under the "Hospital and Skilled Nursing Facility Services" section.

Outpatient magnetic resonance imaging (MRI) and computed tomography (CT)

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% of the Charges incurred.

All other Outpatient diagnostic imaging services

Services for Illness or Injury

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% 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.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

Covered Services:

We cover the following Medically Necessary equipment, supplies and services. Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

- 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 (including polishing and adjustments), 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
- Special dietary treatment for phenylketonuria (PKU) and oral amino acid based elemental formula if it is recommended by a Physician

Diabetic equipment and supplies are covered under the "Diabetic Equipment and Supplies" section.

Special dietary treatment for phenylketonuria (PKU) if it is recommended by a Physician

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% of the Charges incurred.

Oral amino acid based elemental formula

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% of the Charges incurred.

All other durable medical equipment, prosthetics, orthotics and supplies

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% of the Charges incurred.

Limitations:

Coverage of durable medical equipment is limited by the following:

- No more than a 90-day supply of special dietary treatment for phenylketonuria and oral amino acid based elemental formula is covered and dispensed at a time
- Wigs for hair loss resulting from alopecia areata are limited to one per Plan Year
- Payment will not exceed the cost of an alternate piece of equipment or service that is effective and Medically Necessary. This does not apply to hair prostheses (i.e., wigs) for hair loss resulting from alopecia areata and oral appliances for cleft lip and cleft palate.
- We reserve the right to determine if an item will be approved for rental vs. purchase
- Durable medical equipment and supplies must be obtained from or repaired by approved vendors

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 damaged or destroyed by misuse, abuse or carelessness, lost or stolen
- Duplicate or similar items, including replacement or repair of 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
- Charges for repair estimates, sales tax billed separately, mailing, delivery charges and service call charges
- Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience, recreation or safety

- Hair prostheses (wigs), except as described above
- Communication aids or devices: equipment to create, replace or augment communication abilities. This includes, but is not limited to, speech processors, receivers, communication boards, computer or electronic assisted communication and synthesized speech devices with dynamic display.
- Eyeglasses, contact lenses and their fitting, measurement and adjustment, except as described in the "Office Visits for Illness or Injury" section
- Household equipment which primarily has customary uses other than medical, including, but not limited to, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds
- Exercise equipment
- 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 carriers
- 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

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 services. 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.

If other services are performed during the visit, such as diagnostic imaging or laboratory services, additional Deductible and/or Coinsurance may apply. Diagnostic imaging services and laboratory services are covered under the "Diagnostic Imaging Services" and "Laboratory Services" sections.

Services received via video, E-visits or telephone are covered under the "Telehealth/Telemedicine Services" section.

Urgently needed care at clinics

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $35 per visit.	See Network Benefits.

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

"Emergency care" includes emergency services as defined in Division BB, Title I, Section 102 of the Consolidated Appropriations Act of 2021. 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.

When reviewing claims for coverage of emergency services, our medical director will take into consideration (1) whether a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next available clinic appointment or be treated through urgent care; (2) the time of day and day of the week the care was provided; and (3) the presenting symptoms including, but not limited to, severe pain, to ensure that the decision to reimburse the emergency care is not made solely on the basis of the actual diagnosis.

Under the No Surprises Act, Out-of-Network emergency care Providers may not bill patients for more than their cost sharing responsibility for the corresponding Network service.

If emergency services are provided by a nonparticipating Provider, with or without Prior Authorization, the health plan company shall not impose coverage restrictions or limitations that are more restrictive than apply to emergency services received from a participating Provider. Cost-sharing requirements that apply to emergency services received Out-of-Network are the same as the cost-sharing requirements that apply to services received in-Network and count toward the Network Deductible, if applicable. All coverage and Charges for Emergency Services comply with the No Surprises Act.

Emergency care in a Hospital emergency room, including professional services of a Physician

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $50 per visit. Emergency room Copayment is waived if admitted for the same condition within 24 hours.	See Network Benefits. The amount you pay for these services will be determined based on the requirements of the No Surprises Act and its implementing regulations.

Post-stabilization services rendered as part of the visit during which the emergency room services were provided

Network Benefits	Out-of-Network Benefits
Coverage level is same as corresponding Network Inpatient or Outpatient Hospital services benefits depending on the type of service provided.	Coverage level is same as corresponding Network Inpatient or Outpatient Hospital services benefits depending on the type of service provided. The amount you pay for these services will be determined based on the requirements of the No Surprises Act and its implementing regulations.

GENDER AFFIRMING CARE

Definitions:

Gender Affirming Health Care Services. This means all medical, surgical, counseling, or referral services, including telehealth services, that an individual may receive to support and affirm that individual's gender identity or gender expression and that are legal under the laws of the state where the services are provided.

Covered Services:

We cover Gender Affirming Health Care Services, including gender affirming (confirmation) surgery and non-surgical treatment for gender dysphoria.

Log on to your "myHealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

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

GENE THERAPY

Covered Services:

We cover Medically Necessary gene therapy treatment.

Network Benefits	Out-of-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 Coverage Criteria Policies. Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services for more information.

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	Out-of-Network Benefits
100% of the Charges incurred.	80% of the Charges incurred.

HEARING AIDS

Covered Services:

We cover external basic hearing aid devices (including osseointegrated or bone anchored) prescribed by a Provider or by a licensed audiologist for the correction of a hearing impairment.

Osseointegrated or bone-anchored hearing aids are only covered when hearing loss is not correctable by other covered procedures or devices.

Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% of the Charges incurred.

Limitations:

- Coverage is limited to one basic, standard hearing aid for each ear every three years. The three-year limitation is calculated from the date the last hearing aid was purchased for a specific ear, regardless of whether the previous hearing aid was covered under the Certificate. Exceptions to this limitation will be considered based on Medical Necessity, including if the Insured has outgrown the hearing aid; the Insured's hearing has changed; or the hearing aid is no longer functional.
- A basic hearing aid is defined as a hearing device that consists of a microphone, amplifier, volume control, battery and receiver. 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.
- If another type of hearing aid appliance is prescribed, the current cost for a basic, standard hearing aid appliance shall be the amount which is covered toward the cost of such other appliance

Not Covered:

- Charges for upgrades above the cost of a basic, standard hearing aid
- Replacement hearing aid batteries or ear molds
- Duplicate hearing aids
- Replacement hearing aids for items that can be repaired to a functional level or have been lost, stolen or damaged or destroyed by misuse, abuse or carelessness
- Assistive listening devices, frequency modulation (FM) or digital modulation (DM) Systems

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, 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 the "Durable Medical Equipment" section.

You do not need to be homebound to receive total parenteral nutrition/intravenous (TPN/IV) therapy or routine postnatal visits.

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 serious illness or life-limiting condition. 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 for coverage only when all of the following are met:

- Medically Necessary
- Provided as Rehabilitative Care, terminal care or maternity care
- Ordered by a Physician, and included in the written home care plan

Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

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

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% of the Charges incurred.

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

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% 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	Out-of-Network Benefits
100% of the Charges incurred.	80% 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 Plan Year.

Maximum visits for all other services

Network Benefits	Out-of-Network Benefits
120 visits per Plan Year.	60 visits per Plan Year.

Each visit provided under the Network Benefits and Out-of-Network Benefits counts toward the maximums shown above. Routine postnatal well child visits do not count toward the visit maximum.

Limitations:

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

Not Covered:

- Home health services provided as a substitute for a primary caregiver in the home or as relief (respite) for a primary caregiver in the home
- Services provided by family members or residents in your home
- Custodial or Maintenance Care. This includes all services and medical equipment provided for such care.
- Social worker visits
- Services that occur outside of the home are not covered under this "Home Health Services" benefit
- Private duty nursing, except training for ventilator-dependent persons as described in the "Hospital and Skilled Nursing Facility Services" section. This exclusion does not apply to extended nursing services if the Insured is also covered under Medical Assistance under Minnesota chapter 256B to the extent that the services are covered under section 256B.0625, subdivision 7, with the exception of section 256B.0654 subdivision 4.

HOME HOSPICE SERVICES

Definitions:

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

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.

Home Hospice Program. This is a coordinated program of home-based, supportive and palliative care, for terminally ill patients and their families, to assist with the advanced stages of an incurable disease or condition. The services provided are comfort care and are not intended to cure the disease or medical condition, or to prolong life, in accordance with an approved home hospice treatment plan.

Part-time. This is up to two hours of service per day; more than two hours is considered Continuous Care.

Covered Services:

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 treatments with curative intent for the period you are enrolled in the Home Hospice Program.

BENEFITS CHART

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 treatments with curative intent); and (3) continue to meet the terminally ill prognosis as reviewed by our medical director or their 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
  - 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
- Medically Necessary Inpatient services
- Other services:
  - Respite 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
  - Emergency and non-emergency care

Network Benefits	**Out-of-Network Benefits**
90% of the Charges incurred.	80% 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.

Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

Not Covered:

- Rest and respite services, except as described in this "Home Hospice" section
- Custodial Care related to hospice services, whether provided in the home or in a nursing home. This includes all services and medical equipment provided for such care. Custodial Care related to hospice services refers to assistance in the activities of daily living and the care needed by a terminally ill patient which can be provided by a primary caregiver (i.e., family member or friend) who is responsible for the patient's home care.
- Any service not described in this "Home Hospice" section
- Services provided by family members or residents in your home
- Room and board are not covered if the Insured resides in a nursing home or hospice residential Facility
- Costs related to Inpatient confinement when care rendered by the Facility is Custodial
- Bereavement counseling

HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Definitions:

Admission. This is the Medically Necessary admission to an Inpatient Facility for the acute care of Illness or Injury.

Hospital. This is a licensed Facility, lawfully providing medical services in accordance with governmental licensing privileges and limitations, and which is recognized as an Appropriate Facility by us. A hospital is not a nursing home, or convalescent Facility.

Hospital-at-Home. This is a program that allows you to get needed Hospital-level care in your home instead of in the Hospital. A care team including doctors and nurses at the Hospital will provide care to you in your home through a combination of in person visits, virtual (i.e., video and telephone enabled) visits, and remote monitoring technology until you no longer need Hospital-level care.

Inpatient. This is a Medically Necessary confinement for acute care of Illness or Injury, other than in a Hospital's Outpatient department, where a Charge for room and board is made by the Hospital or Skilled Nursing Facility. We cover a semi-private room, unless a Physician recommends that a private room is Medically Necessary. In the event you choose to receive care in a private room under circumstances in which it is not Medically Necessary, our payment toward the cost of the room shall be based on the average semi-private room rate in that Facility.

Outpatient. This is Medically Necessary diagnosis, treatment, services or supplies provided by a Hospital's outpatient department, or a licensed surgical center and other ambulatory Facility (other than in any Physician's office).

Reconstructive Surgery. This is limited to reconstructive surgery, incidental to or following surgery, resulting from Injury, Illness or other disease of the involved part, or to correct a covered Dependent Child's congenital disease or anomaly which has resulted in a functional defect as determined by the attending Physician.

Skilled Nursing Facility. This is a licensed skilled nursing facility, lawfully performing medical services in accordance with governmental licensing privileges and limitations, and which is recognized as an Appropriate Facility by us, to render Inpatient post-acute Hospital and Rehabilitative Care and services to you when your condition requires skilled nursing facility care. It does not include Facilities which provide treatment of mental health or substance use disorders.

Covered Services:

We cover the services described below. Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

We also cover Hospital-level and sub-acute level care in your home instead of in the Hospital when Medically Necessary and provided by a contracted Hospital-at-Home program.

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.

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, Reconstructive Surgery, radiation therapy, physical therapy, Prescription Drugs or other medications administered during treatment, blood and blood products (unless replaced), 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 affirming (confirmation) surgery that meets criteria in our Coverage Criteria Policies.

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 the Newborns' and Mothers' Health Protection Act (NMHPA), restrict benefits for any Hospital length of stay in connection with childbirth for the mother of the 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 the 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	**Out-of-Network Benefits**
90% of the Charges incurred.	80% 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.

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, Reconstructive Surgery, radiation therapy, physical therapy, drugs administered during treatment, administration of Specialty Drugs, blood and blood products (unless replaced), blood derivatives and other diagnostic or treatment-related Outpatient services; Physician and other professional medical and surgical services provided while an Outpatient, including gender affirming (confirmation) surgery that meets criteria in our Coverage Criteria Policies.

To see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see the benefits under "Diagnostic Imaging Services", "Laboratory Services" and "Physical Therapy, Occupational Therapy and Speech Therapy".

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% of the Charges incurred.

Skilled Nursing Facility care. We cover Medically Necessary room and board, daily skilled nursing and related ancillary services for post-acute treatment and Rehabilitative Care of Illness or Injury**.** Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred. Limited to 120 day maximum per Plan Year.	80% of the Charges incurred. Limited to 120 day maximum per Plan Year.

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

Limitations:

- We require Prior Authorization for certain drugs and the site where the drug will be administered. The Formulary and information on drugs with limitations are available by calling Member Services or logging on to your "*my*HealthPartners" account at healthpartners.com.

Not Covered:

- Services for items for personal convenience, such as television rental

INFERTILITY/FERTILITY 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.

We also cover professional fertility treatment services. These services include artificial insemination (AI), intrauterine insemination (IUI), Medically Necessary tests, Facility Charges and laboratory work related to Covered Services.

Fertility drugs are covered under the "Prescription Drugs" section.

Infertility diagnosis

Network Benefits	Out-of-Network Benefits
80% of the Charges incurred.	See Network Benefits.

Fertility treatment

Network Benefits	Out-of-Network Benefits
80% of the Charges incurred.	80% of the Charges incurred.

Annual maximum benefit for fertility services

Network Benefits	Out-of-Network Benefits
$5,000	$5,000

The annual maximum benefit for fertility services under Network Benefits and Out-of-Network Benefits is combined. Fertility drugs are not subject to this maximum.

Not Covered:

- Assisted reproduction (ART), 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
- Fertility treatment after reversal of sterilization
- Sperm, ova or embryo acquisition, retrieval or storage
- Surrogacy/gestational carrier compensation, services and fees
- Maternity services for a surrogate/gestational carrier not covered under the Certificate
- See Reproductive and maternity care in "Services Not Covered"

LABORATORY SERVICES

Covered Services:

This benefit applies to laboratory services when ordered by a Provider and received in a clinic or Outpatient Hospital Facility. Laboratory services received during an Inpatient Hospital or Skilled Nursing Facility stay are covered under the "Hospital and Skilled Nursing Facility Services" section.

Prostate-specific antigen (PSA) testing. We cover prostate cancer screening for individuals age 40 years or older who are symptomatic or in a high-risk category and for all individuals age 50 years or older.

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% of the Charges incurred.

All other laboratory services

Services for Illness or Injury

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% of the Charges incurred.

Preventive services

Laboratory services associated with preventive services are covered at the benefit level shown in the "Preventive Services" section.

LYME DISEASE SERVICES

Covered Services:

We cover services for the treatment of Lyme disease. Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

Network Benefits	Out-of-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 Out-of-Network Benefits depending on type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

MASTECTOMY RECONSTRUCTION

Covered Services:

We cover reconstruction of the breast on which the mastectomy has been performed. 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	Out-of-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 Out-of-Network Benefits depending on type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

MEDICATION THERAPY DISEASE MANAGEMENT PROGRAM

Covered Services:

You may qualify for our Medication Therapy Disease Management Program. The program covers consultations with a designated pharmacist.

Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred.	No coverage.

OFFICE VISITS FOR ILLNESS OR INJURY

Covered Services:

We cover the following:

- Professional medical and surgical services and related supplies of Physicians and other Health Care Providers, including biofeedback and administration of Specialty Drugs
- Blood and blood products (unless replaced) and blood derivatives
- Diagnosis and treatment of Illness or Injury to the eyes. Where contact or eyeglass lenses are prescribed as Medically Necessary for the postoperative treatment of cataracts or for the treatment of aphakia, acute or chronic corneal pathology, or keratoconus, we cover the initial evaluation, lenses and fitting. Insureds must pay for lens replacement beyond the initial pair.
- The initial physical evaluation of a child if it is ordered by a Minnesota juvenile court

Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

If other services are performed during the visit, such as diagnostic imaging or laboratory services, additional Deductible and/or Coinsurance may apply. Diagnostic imaging services and laboratory services are covered under the "Diagnostic Imaging Services" and "Laboratory Services" sections.

Services received via video, E-visits or telephone are covered under the "Telehealth/Telemedicine Services" section.

Office visits

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $35 per visit.	80% of the Charges incurred.

Convenience Clinics. These are clinics that offer a limited set of services and do not require an appointment.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $35 per visit.	80% of the Charges incurred.

Injections administered in a Physician's office, other than routine preventive immunizations

Allergy injections

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $2 per date of service.	80% of the Charges incurred.

All other injections

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $2 per date of service.	80% of the Charges incurred.

Limitations:

- We require Prior Authorization for certain drugs and the site where the drug will be administered. The Formulary and information on drugs with limitations are available by calling Member Services or logging on to your "*my*HealthPartners" account at healthpartners.com.

Not Covered:

- Court ordered services, except as described above or in the "Behavioral Health Services" section
- Eyewear options, including, but not limited to, ultraviolet absorbing properties, scratch resistant or protective coating, sunglasses in addition to other lenses, anti-reflective coating, edge treatment, fashion tints or polarized lenses, frames, contact lens cleaning solution or normal saline for contact lenses, progressive lenses or invisible bifocals, low vision aids or oversize lenses

PEDIATRIC NEUROPSYCHIATRIC CONDITIONS

Definitions:

Pediatric Acute-Onset Neuropsychiatric Syndrome (PANS). 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 (PANDAS). 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 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	Out-of-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 Out-of-Network Benefits depending on type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY

Definitions:

Rehabilitative Care. This is a restorative service, which is provided for the purpose of obtaining significant functional improvement, within a predictable period of time, (generally within a period of two months) toward a patient's maximum potential ability to perform functional daily living activities.

Habilitative Care. This is speech, physical or occupational therapy which is rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and motor development. To be considered habilitative, measurable functional improvement and measurable progress must be made toward achieving functional goals, within a predictable period of time toward an Insured's maximum potential ability.

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 is covered when performed in conjunction with other treatment/modalities by a physical or occupational therapist as part of a prescribed treatment plan and is not billed separately.

Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

Physical therapy, occupational therapy and speech therapy received in a Hospital or Skilled Nursing Facility are covered under the "Hospital and Skilled Nursing Facility Services" section. When received in the home, these services are covered under the "Home Health Services" section.

Rehabilitative Care

Network Benefits	**Out-of-Network Benefits**
90% of the Charges incurred.	80% of the Charges incurred. Physical and Occupational Therapy combined are limited to 20 visits per Plan Year. Speech Therapy is limited to 20 visits per Plan Year.

Habilitative Care

Network Benefits	**Out-of-Network Benefits**
90% of the Charges incurred.	80% of the Charges incurred. Physical, Occupational and Speech Therapy combined are limited to 20 visits per Plan Year.

Not Covered:

- Massage therapy, except as described above
- Maintenance Care

PORT WINE STAIN REMOVAL SERVICES

Covered Services:

We cover port wine stain removal services. Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

Network Benefits	Out-of-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 Out-of-Network Benefits depending on type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

PRE-DIABETES DISEASE MANAGEMENT PROGRAM

Covered Services:

A diabetes prevention program is available through Omada Health for Insureds who qualify for coverage after completing an online assessment.

The Pre-Diabetes Disease Management program offers group health coaching focusing on weight loss, exercise, behavior modification and health education.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred.	Not applicable.

PRESCRIPTION DRUGS

Definitions:

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 a pharmaceutical company. 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.

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 may be granted an exception to the formulary for certain 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.

Formulary exception process for antipsychotic drugs. In accordance with Minnesota Statute 62Q.527, if you are prescribed an antipsychotic drug, we will 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
- The Health Care Provider demonstrates that the Prescription Drug must be dispensed as written to provide maximum medical benefit to the patient
- Certifies in writing to us that the prescribed drug will best treat your condition

NOTE: If you are a new Insured 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

We are not required to provide coverage for a drug if the drug was removed from the Formulary for safety reasons.

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.

Off-label Use of Drugs. Drugs used for a purpose or prescribed in a way that is not included in the labeling approved by the Federal Food and Drug Administration.

Non-Formulary Drug. This is a Prescription Drug, approved by the Food and Drug Administration (FDA), that is not on the Formulary as determined by HealthPartners Pharmacy and Therapeutics Committee.

Prescription Drug. This is any medical substance for prevention, diagnosis or treatment of Injury, disease or Illness approved and/or regulated by the Federal Food and Drug Administration (FDA). It must (1) bear the legend: "Caution: Federal Law prohibits dispensing without a prescription" or "Rx Only"; and (2) be dispensed only by authorized prescription of any Physician or legally authorized Health Care Provider under applicable state law. Drugs that are newly approved by the FDA will be reviewed by HealthPartners Pharmacy and Therapeutics Committee to establish coverage. This process may take up to six months after market availability.

Specialty Drug. These medications are usually prescribed by doctors whose focus is on the treatment of chronic and complex diseases. They usually require more management, have a high price and aren't always stocked at retail pharmacies. Prescriptions for these medications must be filled at a specialty pharmacy and are often covered at a different benefit than non-specialty medications. Specialty drug designations are indicated on the Formulary and may be revised from time to time. Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

Covered Services:

Medically Necessary drugs are based on Coverage Criteria Policies and Formulary guidelines. Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

We cover Prescription Drugs and medications that can be self-administered or are administered in a Physician's office.

We cover all Provider-prescribed, Medically appropriate and Necessary drugs and supplies used in the management and treatment of diabetes for Insureds with gestational, type I or type II diabetes.

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. When Medically Necessary, the same Deductible, Copayment or Coinsurance will apply as if the drug were prescribed for its FDA-approved use.

We cover orally administered anticancer drugs at the applicable benefit level under Outpatient drugs below. In accordance with Minnesota Statute 62A.3075, 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 according to Minnesota Statute 62A.3095 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

We limit your cost-sharing on prescription insulin to no more than the net price of the prescription insulin drug according to Minnesota Statute 62Q.48. This applies at the point of sale, including Deductible payments and the cost-sharing amounts charged once the Deductible is met.

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

The net price is 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.

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.

A Prescription Drug may only be refilled with consent by the prescriber. There are limited exceptions in which a licensed pharmacist may dispense a refill without consent of the prescriber in an emergency situation. When this occurs, the drug will be covered under the same terms that would have applied if the prescriber had consented to a refill.

Your cost-sharing is based on the type of Prescription Drug as described in this section. Coverage will not vary based on the type of authorized Health Care Provider or Physician prescribing the Prescription Drug.

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

Drugs and medications must be part of the Formulary.

If a Copayment is required, you must pay one Copayment for each 34-day supply, or portion thereof, unless otherwise indicated below.

Outpatient drugs (except as specified below)

Network Benefits	**Out-of-Network Benefits**
100% of the Charges incurred, subject to your Copayment of $25. For Outpatient Drugs, you may receive a 90-day supply for two Copayments at participating pharmacies. A list of participating pharmacies is available by calling Member Services.	80% of the Charges incurred.

Mail order drugs

Network Benefits	Out-of-Network Benefits
You may also get Outpatient Formulary Prescription Drugs that can be self-administered through the designated mail order service. Outpatient drugs ordered through this service are covered at the benefit percent shown in Outpatient Drugs above, subject to two Copayments for each 90-day supply, or portion thereof. Specialty Drugs are not available through the mail order service.	Mail order drugs are only available through the designated mail order service. See Network Mail Order Drugs benefit.

Specialty Drugs that are self-administered

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $25. For Network Benefits, Specialty Drugs must be obtained from a designated vendor.	80% of the Charges incurred.

In order for the plan to better manage available manufacturer-funded Copayment assistance, Copayments for certain Specialty medications may vary and be set to approximate the maximum of any available manufacturer-funded Copayment assistance programs. However, in no case will true out-of-pocket costs to the Insured be greater than the maximum Copayment/Coinsurance shown in this Benefits Chart. Manufacturer-funded Copayment assistance received by an Insured will not apply to the Insured's annual Deductible or Out-of-Pocket Limit.

Growth deficiency drugs

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $25. For Network Benefits, growth deficiency drugs must be obtained from a designated vendor.	80% of the Charges incurred.

Fertility drugs

Network Benefits	Out-of-Network Benefits
80% of the Charges incurred.	No coverage.

Annual maximum benefit for fertility drugs

Network Benefits
$3,000

For Network Benefits, fertility drugs are limited to the products listed on the Formulary, even if you have a Non-Formulary benefit for Outpatient drugs.

For Network Benefits, fertility drugs must be obtained from a designated vendor.

Tobacco cessation drugs. This includes all FDA-approved tobacco cessation drugs (including Over-the-Counter drugs) for a minimum of 90 days. Must be prescribed by a licensed Provider.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred.	80% of the Charges incurred.

Contraceptive drugs

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred for Formulary drugs. If a Provider requests that a Non-Formulary contraceptive drug be dispensed as written, the drug will be covered at 100%. Up to a 12-month supply of a prescription contraceptive may be provided when prescribed by a Provider as medically appropriate.	80% of the Charges incurred.

Over-the-Counter medications as listed on the Over-the-Counter (OTC) Drug Program List (available by calling Member Services). Must be prescribed by a Physician or legally authorized Health Care Provider and purchased at a pharmacy.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred.	No coverage.

ACA preventive medications. We cover preventive medications currently recommended by the USPSTF with an A or B rating if they are prescribed by your medical Provider and they are listed on our Commercial ACA Preventive Drug List. Preventive medications are subject to periodic review and modification. Changes would be effective in accordance with the federal rules.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred.	100% of the Charges incurred. Deductible does not apply.

Limitations:

- Certain drugs may require Prior Authorization or have quantity limits. HealthPartners may require Prior Authorization for the drug and also the site where the drug will be provided. The Formulary and information on drugs with limitations are available by calling Member Services or logging on to your "*my*HealthPartners" account at healthpartners.com.
- Certain drugs may be subject to our trial drug program. The trial drug program applies to new prescriptions for certain drugs which have high toxicity, low tolerance, high costs and/or high potential for waste. Trial drugs are indicated on the Formulary. Your first three fills of a trial drug may be limited to less than a month supply. If the drug is well tolerated and effective, you will receive the remainder of your prescribed supply.
- Biosimilar drugs, regardless of interchangeability status, are not considered Generic Drugs and are not covered under the Generic Drug benefit. A biosimilar drug is a Prescription Drug that the FDA has determined is highly similar to a biological Brand Name Drug. HealthPartners will review each biosimilar drug and establish Formulary, coverage and specialty designations.
- Only medical devices approved by the FDA and included on our Formulary are covered under the "Prescription Drugs" section. All other covered medical devices are generally submitted and reimbursed under your medical benefits.
- 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, and we determine the Brand Name Drug is Medically Necessary, the drug will be paid at the Outpatient Drugs 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 Drugs" section, you may receive up to a 34-day supply per prescription
- A 90-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 34-day supply
- No more than a 34-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 34-day supply
- Drugs for the treatment of erectile dysfunction are limited to six doses per month
- For Outpatient Drugs, you may receive a 90-day supply for two Copayments (as shown under Outpatient drugs, above) at participating pharmacies. A list of participating pharmacies is available by calling Member Services.

Not Covered:

- Replacement of Prescription Drugs, equipment and supplies due to loss, damage or theft
- Nonprescription (Over-the-Counter) drugs, including, but not limited to, vitamins, supplements and homeopathic remedies, unless listed on the Formulary, or the Over-the-Counter (OTC) Drug Program List (available by calling Member Services), and prescribed by a Physician or legally authorized Health Care Provider under applicable state and federal law
  - We do cover Over-the-Counter Commercial ACA preventive medications as specified above, including FDA approved Over-the-Counter contraceptives
- Non-FDA approved drugs
- Drugs used for a purpose or prescribed in a way that is not included in the labeling of FDA-approved drugs
  - We do cover Off-label Use of Drugs that are determined to be Medically Necessary as specified above
- Medical foods, unless listed on the Formulary and prescribed by a Physician or legally authorized Health Care Provider under applicable state and federal law
- Weight loss drugs
- 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 as described above.
- Drugs that are newly approved by the FDA until they are reviewed and coverage is established by our Pharmacy and Therapeutics Committee
- Drugs that we determine are Investigative

PREVENTIVE SERVICES

Definitions:

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.

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.

Covered Services:

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

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF) 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 (ACIP) of the Centers for Disease Control and Prevention (CDC) 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
- With respect to women, preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration

Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

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" section) and at least four counseling sessions of at least ten minutes each for tobacco cessation.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred.	100% of the Charges incurred. Deductible does not apply.

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 for children age 18 or younger, 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	Out-of-Network Benefits
100% of the Charges incurred.	100% of the Charges incurred. Deductible does not apply.

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 the American College of Obstetricians and Gynecologists.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred.	100% of the Charges incurred. Deductible does not apply.

Routine postnatal care. This includes comprehensive visits with a Health Care Provider that include a full assessment of the mother's and infant's physical, social, and psychological well-being, including, but not limited to, mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance. Visits include a comprehensive postnatal visit within three weeks of delivery, any recommended postnatal visits 3-11 weeks from delivery and a comprehensive postnatal visit 12 weeks from the date of delivery.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred.	80% of the Charges incurred.

Routine screening procedures for cancer. This includes colorectal screening, digital rectal examinations, or other cancer screenings recommended by the USPSTF with an A or B rating, including the associated preventive office visit Charge. "Women's preventive health services" below describes additional routine screening procedures for cancer.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred.	100% of the Charges incurred. Deductible does not apply.

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	Out-of-Network Benefits
100% of the Charges incurred.	See Network Benefits.

Adult immunizations. This includes routine preventive immunizations indicated on the Adult Immunization Schedule published by the Advisory Committee on Immunization Practices (available at cdc.gov/vaccines/schedules). Immunizations for travel and non-routine immunizations (e.g. rabies) are covered when Medically Necessary under the "Office Visits for Illness or Injury" benefit.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred.	100% of the Charges incurred. Deductible does not apply.

Women's preventive health services. This includes 2D and 3D mammograms; screenings for cervical cancer (pap smears), including the associated preventive office visit Charge; 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 needed for the provision of the contraceptive method (see the "Prescription Drugs" section for coverage of oral contraceptive drugs). For females 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.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred. If a Provider determines that additional diagnostic services or testing is required after a routine mammogram, the additional diagnostic services or testing will be covered at 100% of the Charges incurred.	100% of the Charges incurred. Deductible does not apply.

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	Out-of-Network Benefits
100% of the Charges incurred.	100% of the Charges incurred. Deductible does not apply.

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	Out-of-Network Benefits
100% of the Charges incurred.	100% of the Charges incurred. Deductible does not apply.

Ovarian cancer surveillance tests and associated office visits for individuals 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 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	Out-of-Network Benefits
Coverage level is same as corresponding Network Benefits, 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 Out-of-Network Benefits, 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.

RARE DISEASE DIAGNOSIS AND TREATMENT

Definitions:

Rare Disease or Condition. This is any disease or condition that:

- Affects fewer than 200,000 persons in the United States and is chronic, serious, life-altering, or life-threatening
- Affects more than 200,000 persons in the United States and a drug for treatment has been designated as a drug for a rare disease or condition pursuant to United States Code, title 21, section 360bb
- Is labeled as a rare disease or condition on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health

A rare disease or condition does not include an infectious disease that has widely available and known protocols for diagnosis and treatment and that is commonly treated in a primary care setting, even if it affects less than 200,000 persons in the United States.

Covered Services:

We provide Network Benefits for the diagnosis, monitoring and treatment of a Rare Disease or Condition, as defined above, when received from an Out-of-Network Provider.

We also provide Network Benefits for the diagnosis of a presumed Rare Disease or Condition from an Out-of-Network Provider, as long as you have met all of the following criteria prior to seeking care from an Out-of-Network Provider:

- Have received two or more clinical consultations from a Primary Care Provider or Specialty Care Provider that are specific to the presenting complaint;
- Have documentation in your medical record of a developmental delay through standardized assessment, developmental regression, failure to thrive, or progressive multisystemic involvement; and
- Have had laboratory or clinical testing that failed to provide a definitive diagnosis or resulted in conflicting diagnoses

Network Benefits for these services from an Out-of-Network Provider will be discontinued if you are definitively diagnosed with a disease or condition that does not meet the definition of a Rare Disease or Condition. At that time, any additional services provided by, referred for, or ordered by an Out-of-Network Provider related to the diagnosis are covered at the Network Benefit for up to 60 days following the diagnosis to provide time for care to be transferred to a qualified Network Provider. After this 60-day period, subsequent services provided by, referred for, or ordered by an Out-of-Network Provider related to the diagnosis may be covered as Out-of-Network Benefits.

Call Member Services at the number on the back of your ID card if you have questions on how to obtain this coverage.

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

SPECIFIED OUT-OF-NETWORK SERVICES

Covered Services:

We cover the following services when you elect to receive them from an Out-of-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	Out-of-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 coverage for the services covered.

TELEHEALTH/TELEMEDICINE SERVICES

Definitions:

Telehealth. This is the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Until July 1, 2025, telehealth also includes audio-only communication between a Health Care Provider and a patient.

Telemonitoring Services. This means the remote monitoring of clinical data related to the enrollee's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a Health Care Provider for analysis. Telemonitoring is intended to collect a patient’s health-related data for the purpose of assisting a Health Care Provider in assessing and monitoring the patient's medical condition or status.

Virtual Care. This is a means of communication between a health care professional and a patient. This includes the use of secure electronic information, imaging, and communication technologies, including:

- Telemedicine
- Telehealth
- Chat-based and email-based systems
- Digital diagnostics (algorithm-enabled diagnostic support)
- Digital therapeutics (the use of personal health devices and sensors, either alone or in combination with conventional drug therapies, for disease prevention and management)
- Telemonitoring services

Services can be delivered:
Synchronously: the patient and health care professional are engaging with one another at the same time
Asynchronously: the patient and health care professional engage with each other at different points in time.

Telephone Visits. Live, synchronous, interactive encounters over the telephone between a patient and a Health Care Provider.

E-visit or chat-based visits. Asynchronous online or mobile app encounters to discuss a patient's personal health information, vital signs, and other physiologic data or diagnostic images. The Health Care Provider reviews and delivers a consultation, diagnosis, prescription or treatment plan after reviewing the patient's visit information.

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

Video Visits. Live, synchronous, interactive encounters using secure web-based video between a patient and a Health Care Provider.

Covered Services:

The plan covers the following methods of receiving care for services that would be eligible under the plan if the services were provided in person.

Scheduled Telephone Visits

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $35 per visit.	80% of the Charges incurred.

Virtuwell visits through virtuwell.com

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred.	Not applicable.

E-visits

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $35 per visit.	80% of the Charges incurred.

Video Visits

Network Benefits	Out-of-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 Out-of-Network Benefits, depending on type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

TRANSPLANT SERVICES

Definitions:

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

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.

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).

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:

For Network Benefits, Transplant Services must be received at a Designated Transplant Center. Covered Services provided by a Network Facility that is not a Designated Transplant Center will be covered under the Out-of-Network Benefits.

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
- Cornea transplants
- Heart transplants
- Lung transplants or heart/lung transplants
- Liver transplants
- Allogeneic Bone Marrow Transplants or peripheral stem cell support associated with high dose chemotherapy
- Autologous Bone Marrow Transplants or peripheral stem cell support associated with high-dose chemotherapy
- Simultaneous pancreas-kidney transplants, pancreas after kidney transplant, living related segmental simultaneous pancreas kidney transplantation and pancreas transplant alone

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. Unless the donor is a family member covered under the same policy, donors are not considered Insureds and are therefore not eligible for the rights afforded to Insureds under the Certificate. Ongoing medical care and/or treatment of medical complications that may occur to the donor are not covered. When the donor is a family member covered under the same policy, medical and Hospital expenses of the donor are covered.

Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply and to view a list of Designated Transplant Centers.

Network Benefits	**Out-of-Network Benefits**
90% of the Charges incurred.	80% of the Charges incurred.

Not Covered:

- For Network Benefits, Transplant Services provided by a Facility that is not a Designated Transplant Center. Covered Services provided by a Network Facility that is not a Designated Transplant Center will be covered under the Out-of-Network Benefits. This does not apply to coverage required by the No Surprises Act as described in this Benefits Chart and the Certificate or to an Out-of-Network Provider as described in the "Out-of-Network Provider Balance Billing Prohibition" section of the Certificate.
- Transplants not listed in our Coverage Criteria Policies
- Surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, except as described above
- Non-human organ implants and/or transplants

TRAVEL BENEFIT

Covered Services:

We may provide travel and lodging when an Insured needs a transplant or Chimeric antigen receptor T-cell (CAR-T) therapy and a Designated Transplant Center or CAR-T treatment center is greater than 100 miles from the Insured's primary address.

Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

To receive reimbursement for eligible travel and lodging expenses, the Insured will need to submit a Travel Benefit Claim Form, including receipts of services.

Subject to the Network Out-of-Pocket Limits.

Benefits
90% of the Charges incurred. Expenses for travel and lodging for the Insured (the recipient) and one adult companion may be covered up to a maximum of $10,000 per transplant or CAR-T therapy. Commercial lodging reimbursement (as may be adjusted by IRS rules) is limited to a maximum of $50 per night if the Insured travels alone or a maximum of $100 per night if the Insured travels with a companion.

Not Covered:

- Travel, transportation, meals or lodging expenses, except as specified above

WEIGHT LOSS SURGERY OR BARIATRIC SURGERY

Covered Services:

For Network Benefits, all services for weight loss surgery or bariatric surgery must be received from a Designated Weight Loss Surgery Provider. Covered Services provided by a Network Facility or Physician who is not a Designated Weight Loss Surgery Provider will be covered under the Out-of-Network Benefits. If you reside outside of the region of Designated Weight Loss Surgery Providers, we will work with you to find an approved Network Provider.

Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply and to obtain a current list of Designated Weight Loss Surgery Providers.

Network Benefits	**Out-of-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 Out-of-Network Benefits, depending on type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

Lifetime Maximum Benefit for bariatric surgery

Network Benefits	**Out-of-Network Benefits**
Unlimited.	$5,000

Not Covered:

- For Network Benefits, all services for weight loss surgery or bariatric surgery not received from a Designated Weight Loss Surgery Provider, except as described in the "Out-of-Network Provider Balance Billing Prohibition" section of the Certificate. Covered Services provided by a Network Facility or Physician who is not a Designated Weight Loss Surgery Provider will be covered under the Out-of-Network Benefits. If you reside outside of the region of Designated Weight Loss Surgery Providers, we will work with you to find an approved Network Provider.
- See Weight loss services in "Services Not Covered"

SERVICES NOT COVERED

This is one of several sections you need to review to understand your benefits and what you will pay when you receive care. Please also refer to any "Limitations" and "Not Covered" lists within individual benefit categories, as well as limitations and terms specified in the Certificate. Additional coverage information is available in our Coverage Criteria Policies and Formulary. Log on to your "*my*HealthPartners" account or call Member Services to determine if additional requirements apply.

Unless coverage is required by law or specifically described in this Benefits Chart, we will not cover any Charges for the services, treatments, items or supplies described in this section. This is true even if a Physician or Health Care Provider recommends or orders it.

To help you find exclusions in this section, we use headings. A heading does not define, change or limit an exclusion. All exclusions in this section apply to you.

Certifications/Examinations

Any health services, certifications or examinations required by a third party when not otherwise Medically Necessary or eligible preventive care. This includes, but is not limited to, services:

- To get or keep a job, including vocational assessments
- Required under a labor agreement or other contract
- Needed for legal proceedings. This includes, but is not limited to, services related to custody evaluations, parenting assessments, adoption studies, reports to the court, risk assessments for sexual offenses, educational classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) competency evaluations. This exclusion does not apply to substance use disorder treatment for which coverage is required by Minnesota Statute 62Q.137.
- For purposes of insurance
- To get or keep a license

Dental services

- Dental treatment, procedures or services not described under the "Dental Services" section. Examples of Covered Services include Medically Necessary coverage for temporomandibular disorder (TMD) and craniomandibular disorder (CMD).
- Accident-related dental services when any of the following is true about your treatment:
  - Provided to teeth which are not: sound, natural and unrestored
  - Initiated beyond six months from the date of the Injury
  - Received beyond the initial treatment or restoration
  - Received beyond 24 months from the date of Injury
- Oral surgery to remove wisdom teeth

Investigative services

We do not cover the use of any item or service we determine is Investigative or otherwise not Clinically Accepted, including, but not limited to, procedures, treatments, technologies, equipment, devices, facilities and drugs.

For more information on how we determine when an item or service is investigational, see the definition of Investigative in the "General Definitions" section.

Nutrition

- Medical foods
- Enteral feedings, unless they are the sole source of nutrition used to treat a life-threatening condition
- Nutritional supplements, Over-the-Counter electrolyte supplements and infant formula. This exclusion does not apply to special dietary treatment for phenylketonuria (PKU) if it is recommended by a Physician or oral amino acid based elemental formula or other items if they meet criteria in our Coverage Criteria Policies.

Physical appearance

- Surgery, services, treatments or drugs that improve or enhance the shape or appearance of the body for purposes other than treating an Illness or Injury. These types of services are considered cosmetic and are not covered whether or not they also impact the psychological/emotional well-being or self-esteem of the Insured. Examples include, but are not limited to, enhancement procedures, reduction procedures and scar revision surgery. This exclusion does not apply to services for port wine stain removal, Reconstructive Surgery, Gender Affirming Health Care Services and emergency care required due to complications of Cosmetic Surgery.
- Hair prostheses (wigs), except as described in the "Durable Medical Equipment, Prosthetics, Orthotics and Supplies" section

Providers/Network

- Network Benefits for services received from Out-of-Network Providers*
- Out-of-Network billed Charges above the usual and customary charge*
- For Network Benefits, Transplant Services provided by a Facility that is not a Designated Transplant Center*. Covered Services provided by a Network Facility that is not a Designated Transplant Center will be covered under the Out-of-Network Benefits.
- Services from Providers or Facilities that are not licensed
- Services outside the scope of practice or license of the individual or Facility providing the services

*These items do not apply to coverage required by the No Surprises Act as described in this Benefits Chart and the Certificate or to an Out-of-Network Provider as described in the "Out-of-Network Provider Balance Billing Prohibition" section of the Certificate

Reproductive and maternity care

- Assisted reproduction (ART), 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
- Fertility treatment after reversal of sterilization
- Sperm, ova or embryo acquisition, retrieval or storage
- Surrogacy/gestational carrier compensation, services and fees
- Maternity services for a surrogate/gestational carrier not covered under the Certificate
- Elective home births

Services that are not Medically Necessary

We cover services that are appropriate in terms of type, frequency, level, setting and duration to your diagnosis or condition. Services that are outside of generally accepted practice guidelines are not covered. This includes, but is not limited to:

- Treatment, procedures, services or drugs that do not meet our definition of Medically Necessary Care as explained in the "General Definitions" section
- Services primarily educational in nature, including, but not limited to, nonmedical self-care or self-help training. This also includes programs to help you develop academic skills (educational therapy).
- Skills training
- Services needed because of your job. This includes programs to help you prepare for, find and/or keep a job (vocational rehabilitation).
- Services related to activities you do for enjoyment. This includes recreational therapy and physical or occupational therapy to improve athletic ability. It also includes braces or guards to prevent sports injuries.
- Any service or item not used for a medical need or purpose. This includes items and services for comfort, convenience or appearance.

Types of care

- Services provided by naturopathic providers. Naturopathic providers are specialists in natural treatment of primary care conditions who prevent, assess and treat injuries, conditions and diseases using complementary and alternative health care practices.
- Music therapy
- Massage therapy as a standalone treatment
- Routine foot care, unless you have one of the systemic conditions listed in our Coverage Criteria Policies. This includes metabolic, neurologic, or peripheral vascular disease that has resulted in severe circulatory compromise or areas of desensitization in the legs or feet. Call Member Services or log on to your "*my*HealthPartners" account at healthpartners.com for more information.
- Rest and respite services, including all services and medical equipment provided for such care, except as described under the "Home Hospice Services" section
- Custodial Care or Maintenance Care, including all services and medical equipment provided for such care
- Services provided by family members or residents in your home
- Halfway houses, group homes, extended care facilities, shelter services, transitional services, housing support programs, housing stabilization and low intensity residential treatment for substance use disorders

- Correctional services and detention services
- Wilderness and outdoor programs even when the program is through a licensed Facility
- Animal therapy, including hippotherapy and equine therapy
- Foster care, adult foster care and any type of family childcare provided or arranged by the local state or county
- Court-ordered services or treatment unless coverage is described in the "Behavioral Health Services" or "Office Visits for Illness or Injury" sections
- Private duty nursing, except training for ventilator-dependent persons as described in the "Hospital and Skilled Nursing Facility Services" section. This exclusion does not apply to extended nursing services if the Insured is also covered under Medical Assistance under Minnesota chapter 256B to the extent that the services are covered under section 256B.0625, subdivision 7, with the exception of section 256B.0654, subdivision 4.

Vision services

- Vision correction (refractive) surgeries in otherwise healthy eyes to replace eyeglasses or contact lenses. Examples include, but are not limited to, LASIK, radial keratotomy, laser and other refractive eye surgery.
- Eyeglasses, contact lenses and their fitting, measurement and adjustment, except as described in the "Office Visits For Illness or Injury" section

Weight loss services

- For Network Benefits, all services for weight loss surgery or bariatric surgery not received from a Designated Weight Loss Surgery Provider, except as described in the "Out-of-Network Provider Balance Billing Prohibition" section of the Certificate. Covered Services provided by a Network Facility or Physician who is not a Designated Weight Loss Surgery Provider will be covered under the Out-of-Network Benefits. If you reside outside of the region of Designated Weight Loss Surgery Providers, we will work with you to find an approved Network Provider.
- Commercial weight loss centers, support groups and programs
- Nutritional supplements, foods and phytotherapy, including, but not limited to, vitamins, amino acid supplements and commercially prepared or pre-packaged foods
- Acupuncture for weight loss
- Biofeedback for weight loss
- Inpatient or day treatment programs for weight loss
- Weight loss drugs

All other exclusions

- Communication aids or devices: equipment to create, replace or augment communication abilities. This includes, but is not limited to, speech processors, receivers, communication boards, computer or electronic assisted communication and synthesized speech devices with dynamic display.
- All services, testing, equipment, devices, technologies and supplies purchased or available Over-the-Counter, including those recommended or managed by a Health Care Provider
- Health club memberships, exercise programs and use or purchase of exercise equipment
- Physical performance testing and measurement as part of an exercise program
- Lifestyle-behavioral resources or equipment, including, but not limited to, support groups and programs
- Services associated with non-covered Services, including, but not limited to, treatment, procedures, diagnostic tests, monitoring, laboratory services, drugs and supplies. This exclusion does not apply to Medically Necessary complications related to an excluded service if they would otherwise be covered under the Certificate.
- Non-medical administrative costs, including, but not limited to:
  - Medical record preparation or mailing
  - Appointment cancellation fees
  - After hours appointment charges
  - Interest charges
  - Sales tax
- Charges for phone, data, software or mobile applications/apps unless described as covered in our Coverage Criteria Policies for the device or service
- Treatment, procedures, services, supplies or drugs received when you are not covered under the Certificate
- Services that would not otherwise be charged if you did not have health plan coverage
- Services you have no legal obligation to pay
- Replacement of Prescription Drugs, equipment and supplies due to loss, damage or theft
- Autopsies

- Financial or legal counseling services
- Housekeeping or meal services
- Duplicate charges or charges for duplicate services
- Claims that are paid by other primary insurance coverage
- Services or items prohibited by law in the applicable jurisdiction in which they are received

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 and sexual orientation.

- 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)	ຄ່ນ ລົາວ *(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)	ر،،ا ةيب *(Arabic)* تنبيه :إذا كنت تتحدث العربية ، فإن خدمات المساعدة اللغوية مجانية لك (1-800-883-2177. اتصل بـ :711
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)* 0 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) 번으로 전화해 주십시오.
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)
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)
ኣማርኛ *(Amharic)* ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ 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)* သတိပြုရန် - သင်အူရဒူစကားပြောဆိုပါကဘာသာစကားအကူအညီဝန်ဆောင်မှုများသည်အခမဲ့ဖြစ်သည်။ 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: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको 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)
اردو *(Urdu)* ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-883-2177 (رقم هاتف الصم والبكم:711 (TTY:).	Українська *(Ukrainian)* УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-883-2177. (телетайп: 711)