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, 2026 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 Coverage Criteria Policies and your Drug Formulary.

Our Coverage Criteria Policies list specific criteria that must be met for certain supplies, Health Care Services, behavioral health services, Outpatient professionally administered injections/infusions 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 will determine eligibility for some services based on the terms of this Benefits Chart and Coverage Criteria Policies which are subject to periodic review and modification. To learn more about our Coverage Criteria Policies or your Formulary, sign in to your online 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 the online Network 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 definitions of Charge and Usual and Customary 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 Emergency 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.

A charge may include a cash price for a service or item.

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. A charge is incurred for all other Covered Services on the date the service or item is provided. Fees and related charges for services that have not yet been provided are not eligible for coverage.

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.

Charges above the Usual and Customary Charge do not apply to the deductible. See the definition of Usual and Customary Charge in this "General Definitions" section.

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.

Deductible Carryover. Charges incurred in the last three months of the Plan Year for which this Benefits Chart is effective, which are applied to any Deductible for this 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.

Investigational or Experimental. As determined by us, a Drug, device, medical, behavioral health or dental treatment or procedure is investigational or experimental if reliable evidence does not permit conclusions concerning its safety, effectiveness, or positive effect on health outcomes and will be considered investigational or experimental 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 the United States Food and Drug Administration (FDA) has approved a Drug or device to be lawfully marketed for its proposed use; and
- The Drug, 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 (i.e., the beneficial effects outweigh any harmful effects) of the service or treatment when compared to standard established service or treatment. To constitute evidence, an 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-reviewed 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 for an Insured for a given procedure or diagnosis. Payment of benefits under this Benefits Chart ceases for that Insured when that lifetime maximum benefit is reached. The Insured has 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 the 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.

Charges above the Usual and Customary Charge do not apply to the out-of-pocket limit. See the definition of Usual and Customary Charge in this "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.

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 designee, that an Admission, extension of stay, or other Health Care Service (including Prescription Drugs) 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.

Usual and Customary Charge. This is the maximum amount allowed that we consider in the calculation of payment of Charges incurred for certain Covered Services received from Out-of-Network Providers. It is consistent with the range of reasonable fees charged by other Providers of a given service or item in the same geographic region.

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.

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

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
$1,500	$2,000

Family Plan Year Out-of-Pocket Limit

Network Benefits	Out-of-Network Benefits
$3,000	$4,000

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

Charges above the Usual and Customary Charge will not apply toward the individual or family Out-of-Pocket Limit. See the definition of Usual and Customary 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.

We will not deny coverage for habilitative or rehabilitative benefits, including prostheses or orthoses, solely on the basis of an Insured's actual or perceived disability. We will not deny a prosthesis or orthosis benefit for an individual with limb loss or absence that would otherwise be covered for a nondisabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

ACUPUNCTURE

Covered Services:

We cover acupuncture services when Medically Necessary. Sign in to your HealthPartners online account 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, after the Deductible. Charges are based on the Usual and Customary Charge.

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.

Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

Ambulance and medical transportation (other than medical Facility transfers related to maternity care described below)

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. Coverage level for Emergency ambulance services received or originating outside of the US or US Territories is 80% of the Charges incurred, after the Out-of-Network Deductible. Charges are based on the Usual and Customary Charge. Emergency ambulance services received or originating outside of the US or US Territories are subject to the Out-of-Network Out-of-Pocket Limit. US air ambulance Providers are considered within the US.

Medical Facility transfers related to maternity care. This includes expenses related to transferring all individuals (mother, newborn and any newborn siblings, if applicable) from one medical Facility to a different medical Facility if a Health Care Provider acting within the Provider's scope of practice recommends that either the mother or newborn be transferred to a different medical Facility.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred.	90% of the Charges incurred. Deductible does not apply. Usual and Customary Charge provision does not apply.

Not Covered:

- Non-emergent Health Care Services delivered or items supplied from providers located outside of the United States or US Territories. Emergency Services from non-US providers and post-stabilization services rendered as part of the visit during which the emergency room services were provided will be covered as Out-of-Network Benefits.

AUTISM SERVICES

Covered Services:

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 to treat autism spectrum disorders. Covered Services include, but are not limited to, early intensive behavioral and developmental therapy based in behavioral and developmental science, including, but not limited to, all types of applied behavior analysis (ABA) and early intensive behavioral intervention (EIBI).

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. Neurodevelopmental and behavioral health treatments and management are covered the same as corresponding benefits, such as Behavioral Health Services or Office Visits for Illness or Injury.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $35 per visit.	80% of the Charges incurred, after the Deductible. Charges are based on the Usual and Customary Charge.

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.

Psychiatric Residential Treatment Facility (PRTF). This is a Facility that provides Medically Necessary treatment to individuals age 20 and younger with complex mental health needs. Physician-directed treatment is provided seven days per week at an Inpatient level of care.

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). Sign in to your HealthPartners online account 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. This court-ordered treatment shall not be subject to a separate Medical Necessity determination under our utilization review procedures.

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
- Psychiatric collaborative care
- Treatment for gender dysphoria

Services received via video, E-visit 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, after the Deductible. Charges are based on the Usual and Customary Charge.

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, after the Deductible. Charges are based on the Usual and Customary Charge.

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 Inpatient services in a Psychiatric Residential Treatment Facility (PRTF)
- Medically Necessary mental health residential treatment services. This includes the treatment of emotionally disabled Children. This care must be Prior 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, after the Deductible. Charges are based on the Usual and Customary Charge.

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. Sign in to your HealthPartners online account 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
- Psychiatric collaborative care
- 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, after the Deductible. Charges are based on the Usual and Customary Charge.

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, after the Deductible. Charges are based on the Usual and Customary Charge.

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, except as specifically described above
- 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 provided to diagnose and treat neuromusculoskeletal conditions. 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.

Sign in to your HealthPartners online account 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, after the Deductible. Charges are based on the Usual and Customary Charge. 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.

Sign in to your HealthPartners online account 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.

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:

Dental services are limited to those specifically described in this section. Sign in to your HealthPartners online account 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 a dental implant is pursued, reimbursement for the implant and any associated procedures (including bone grafting, implant placement and restoration) is limited to the amount that would be paid toward the fabrication of a removable dental prosthesis.

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% of the Charges incurred, after the Deductible. Charges are based on the Usual and Customary Charge.

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, after the Deductible. Charges are based on the Usual and Customary Charge.

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 an 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, ambulatory surgery center 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, after the Deductible. Charges are based on the Usual and Customary Charge.

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, after the Deductible. Charges are based on the Usual and Customary Charge.

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 jaw, trauma of the mouth and jaw, 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, after the Deductible. Charges are based on the Usual and Customary Charge.

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, after the Deductible. Charges are based on the Usual and Customary Charge.

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, after the Deductible. Charges are based on the Usual and Customary Charge.

Treatment of temporomandibular disorder (TMD) and craniomandibular disorder (CMD). We cover diagnostic procedures, surgical treatment and non-surgical treatment for TMD and CMD. Coverage is the same as treatment to any other joint in the body and applies if the treatment is 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, after the Deductible. Charges are based on the Usual and Customary Charge.

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
- For accident-related dental services, the cost of dental implants and any associated procedures (including bone grafting, implant placement and restoration) in excess of the amount that would be paid toward the fabrication of a removable dental prosthesis
- 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. Sign in to your HealthPartners online account 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 a Designated Vendor. In accordance with Minnesota Statute 62Q.481, your combined cost for medical supplies used to treat diabetes, asthma or allergies that require the use of epinephrine auto-injectors will not exceed $50 per month, regardless of whether received through a pharmacy or a non-pharmacy Network Provider.	80% of the Charges incurred, after the Deductible. Charges are based on the Usual and Customary Charge.

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 a Designated Vendor. In accordance with Minnesota Statute 62Q.481, your combined cost for medical supplies used to treat diabetes, asthma or allergies that require the use of epinephrine auto-injectors will not exceed $50 per month, regardless of whether received through a pharmacy or a non-pharmacy Network Provider.	80% of the Charges incurred, after the Deductible. Charges are based on the Usual and Customary Charge.

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 Designated 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, destroyed, 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 a Designated 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, after the Deductible. Charges are based on the Usual and Customary Charge.

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, after the Deductible. Charges are based on the Usual and Customary Charge.

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, PROSTHESES, ORTHOSES AND SUPPLIES

Definitions:

Durable Medical Equipment (DME). An item is considered durable medical equipment and may be covered if all of the following apply:

- Prescribed by a Health Care Provider
- Can withstand repeated use
- Is primarily and customarily used to serve a medical purpose
- Generally is not useful to a person in the absence of an Illness or Injury

Covered Services:

We cover the following Medically Necessary equipment, supplies and services. Sign in to your HealthPartners online account 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
- Orthoses and prostheses. This includes:
  - Breast prostheses, artificial limbs and artificial eyes (including polishing and adjustments), and related supplies
  - Orthoses and prostheses as determined by the Insured's Provider to be the most appropriate model that meets the medical needs of the Insured for the purposes of performing physical activities including, but not limited to, running, biking, and swimming, and maximizing the Insured's limb function
  - Devices or device systems, supplies, accessories, and services that are customized to the Insured's needs
  - Orthoses and prostheses for showering or bathing
- Scalp hair prostheses (wigs) for hair loss resulting from a health condition, including, but not limited to, alopecia areata and the treatment for cancer, including necessary equipment and accessories. Scalp hair prostheses must be prescribed by a Provider.
- Replacement or repair of DME, prostheses or orthoses is covered to accommodate growth requirements or if needed due to a change in a medical condition which affects the fit or function of the item
- Medical supplies, including catheters, splints, surgical stockings, casts and dressings
- Enteral feedings
- Special dietary treatment for phenylketonuria (PKU) and 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, after the Deductible. Charges are based on the Usual and Customary Charge.

Amino acid based elemental formula

Network Benefits	**Out-of-Network Benefits**
90% of the Charges incurred.	80% of the Charges incurred, after the Deductible. Charges are based on the Usual and Customary Charge.

All other Durable Medical Equipment, prostheses, orthoses and supplies

Network Benefits	**Out-of-Network Benefits**
90% of the Charges incurred. In accordance with Minnesota Statute 62Q.481, your combined cost for medical supplies used to treat diabetes, asthma or allergies that require the use of epinephrine auto-injectors will not exceed $50 per month, regardless of whether received through a pharmacy or a non-pharmacy Network Provider.	80% of the Charges incurred, after the Deductible. Charges are based on the Usual and Customary Charge.

Limitations:

Coverage of Durable Medical Equipment is limited by the following:

- Wigs for hair loss resulting from a health condition are limited to one per Plan Year
- We will cover at least 180 intermittent urinary catheters per month and may cover more in accordance with the current National Coverage Determination/Local Coverage Determination released by Centers for Medicare & Medicaid Services (CMS) and Medicare Administrative Contractor (MAC)

- 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 a health condition and oral appliances for cleft lip and cleft palate.
- Coverage is limited to one prosthesis unless bilateral prostheses are recommended and are Medically Necessary for both sides
- We reserve the right to determine if an item will be approved for rental vs. purchase
- Durable Medical Equipment, prostheses, orthoses and supplies must be obtained from or repaired by Designated 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, destroyed, lost or stolen
- Duplicate or similar items, including replacement or repair of duplicate or similar items
- Labor and related charges for repair of prostheses and orthoses which are more than 60% of the cost of replacement by a Designated Vendor. Labor and related charges for repair of any other covered items which are more than the cost of replacement by a Designated 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. The exclusion for items for hygiene does not apply to orthoses and prostheses for showering or bathing as described above. The exclusion for items for recreation does not apply to appropriate orthoses and prostheses used for physical activities as determined by a Provider and described above.
- Hair prostheses (wigs) for cosmetic purposes including androgenic alopecia (pattern baldness). This does not apply to wigs for hair loss resulting from a health condition 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-visit 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. Coverage level for Emergency Services received outside of the US or US Territories is 80% of the Charges incurred, after the Out-of-Network Deductible. Charges are based on the Usual and Customary Charge. Emergency Services received outside of the US or US Territories are subject to the Out-of-Network Out-of-Pocket Limit.

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. Coverage level for Emergency Services received outside of the US or US Territories is 80% of the Charges incurred, after the Out-of-Network Deductible. Charges are based on the Usual and Customary Charge. Emergency Services received outside of the US or US Territories are subject to the Out-of-Network Out-of-Pocket Limit.

Not Covered:

- Non-emergent Health Care Services delivered or items supplied from providers located outside of the United States or US Territories. Emergency Services from non-US providers and post-stabilization services rendered as part of the visit during which the emergency room services were provided will be covered as Out-of-Network Benefits.

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 gender affirming treatments.

Sign in to your HealthPartners online account 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 the 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. Sign in to your HealthPartners online account 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, after the Deductible. Charges are based on the Usual and Customary Charge.

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.

Sign in to your HealthPartners online account 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, after the Deductible. Charges are based on the Usual and Customary Charge.

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. 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 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

Sign in to your HealthPartners online account 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, after the Deductible. Charges are based on the Usual and Customary Charge.

TPN/non-specialty 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, after the Deductible. Charges are based on the Usual and Customary Charge.

Specialty Drug injections and infusions administered by a Health Care Provider

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% of the Charges incurred, after the Deductible. Charges are based on the Usual and Customary Charge.

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, after the Deductible. Charges are based on the Usual and Customary Charge.

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:

- Respite care in your 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

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.

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.

BENEFITS CHART

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, after the Deductible. Charges are based on the Usual and Customary Charge.

Respite care is limited to five days per episode and respite care and Continuous Care combined are limited to 30 days.

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.
- 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. Sign in to your HealthPartners online account 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:

- Room and board, the use of operating or maternity delivery rooms, intensive care Facilities and newborn nursery Facilities
- General nursing care, anesthesia, laboratory and diagnostic imaging services, Reconstructive Surgery, radiation therapy, physical therapy, gender affirming (confirmation) surgery that meets criteria in our Coverage Criteria Policies and other diagnostic or treatment-related Inpatient services
- Prescription Drugs or other medications administered during treatment, blood and blood products (unless replaced) and blood derivatives
- Physician and other professional medical and surgical services

We cover up to 120 hours of services provided by a home care 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, after the Deductible. Charges are based on the Usual and Customary Charge.

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:

- Use of operating rooms, maternity delivery rooms or other Outpatient departments, rooms or Facilities
- General nursing care, anesthesia, Reconstructive Surgery, radiation therapy, physical therapy, gender affirming (confirmation) surgery that meets criteria in our Coverage Criteria Policies, and other diagnostic or treatment-related Outpatient services
- Drugs administered during treatment, blood and blood products (unless replaced) and blood derivatives
- Physician and other professional medical and surgical services

To see the benefit level for diagnostic imaging services and laboratory services, see the benefits under "Diagnostic Imaging Services" and "Laboratory Services". To see the benefit for injections administered in an Outpatient Hospital, see the benefits under "Outpatient Professionally Administered Injections and Infusions".

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% of the Charges incurred, after the Deductible. Charges are based on the Usual and Customary Charge.

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. Sign in to your HealthPartners online account 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, after the Deductible. Charges are based on the Usual and Customary Charge. 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.

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, after the Deductible. Charges are based on the Usual and Customary Charge.

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
- Compensation fees for surrogates/gestational carriers
- 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.

Biomarker testing to diagnose, treat, manage, and monitor an Illness or a disease may be covered when the test provides information that is used to make clinical decisions, such as determining a treatment or monitoring strategy that impacts a patient's outcome. Sign in to your HealthPartners online account or call Member Services to determine if Coverage Criteria Policies apply. BRCA testing for females whose family history is associated with an increased risk for BRCA1 or BRCA2 gene mutations is covered under the "Women's preventive health services" benefit.

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, after the Deductible. Charges are based on the Usual and Customary Charge.

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, after the Deductible. Charges are based on the Usual and Customary Charge.

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. Sign in to your HealthPartners online account 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.

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 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.

MEDICATION THERAPY DISEASE MANAGEMENT PROGRAM

Covered Services:

You may qualify for our Medication Therapy Disease Management Program. The program covers consultations with a Designated Network Pharmacist. Sign in to your HealthPartners online account 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
- Blood (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

Sign in to your HealthPartners online account 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. To see the benefit for injections administered in an office, see the benefits under “Outpatient Professionally Administered Injections and Infusions”.

Services received via video, E-visit 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, after the Deductible. Charges are based on the Usual and Customary Charge.

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, after the Deductible. Charges are based on the Usual and Customary Charge.

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

OUTPATIENT PROFESSIONALLY ADMINISTERED INJECTIONS AND INFUSIONS

Covered Services:

We cover injections and infusions administered in a Physician's office or Outpatient Facility, including professional administration of Drugs and blood products. Injections and infusions received in the home are covered under the "Home Health Services" benefit.

Allergy injections

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% of the Charges incurred, after the Deductible. Charges are based on the Usual and Customary Charge.

All other injections and infusions (other than routine preventive immunizations)

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred.	80% of the Charges incurred, after the Deductible. Charges are based on the Usual and Customary Charge.

Limitations:

- We require Prior Authorization for certain Drugs and the site where the Drug will be administered. Sign in to your HealthPartners online account or call Member Services to determine if additional Coverage Criteria Policies apply.

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 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.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY

Definitions:

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 a patient's maximum potential ability.

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. Accordingly, Skilled Nursing Facility care, home health services and physical or occupational therapy services for chronic medical conditions, or long-term disabilities, where progress toward such functional improvement is not anticipated, do not constitute "rehabilitative care" under the Certificate.

Covered Services:

We cover the following physical therapy, occupational therapy and speech therapy services provided in a clinic:

- 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.

Sign in to your HealthPartners online account 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, after the Deductible. Charges are based on the Usual and Customary Charge. 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, after the Deductible. Charges are based on the Usual and Customary Charge. 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 elimination or maximum reasonable treatment of port wine stains. Sign in to your HealthPartners online account 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.

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 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 signing in to your HealthPartners online account.

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 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 FDA.

Non-Formulary Drug. This is a Prescription Drug, approved by the 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 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 and indications 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. Sign in to your HealthPartners online account 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. Sign in to your HealthPartners online account 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 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.

We cover pre-exposure prophylaxis and postexposure prophylaxis when used for the prevention or treatment of human immunodeficiency virus. This includes, but is not limited to, pre-exposure prophylaxis and postexposure prophylaxis as defined in any guidance by the United States Preventive Services Task Force or the Centers for Disease Control.

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. In addition, a licensed pharmacist may prescribe, dispense and administer Drugs to prevent the acquisition of human immunodeficiency virus (HIV) and may order, conduct, and interpret laboratory tests necessary for therapies that use Drugs for preventing the acquisition of HIV and refer the patient to other health care providers for follow-up care. Licensed pharmacists may also administer influenza and COVID-19 or SARS-CoV-2 vaccines according to ACIP recommendations.

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. In accordance with Minnesota Statute 62Q.481, your cost for a Prescription Drug used to treat diabetes, asthma or allergies that require the use of epinephrine auto-injectors will not exceed $25 for a one-month supply. Your combined cost for medical supplies used to treat diabetes, asthma or allergies that require the use of epinephrine auto-injectors will not exceed $50 per month. 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, after the Deductible. Charges are based on the Usual and Customary Charge.

Mail order Drugs

Network Benefits	Out-of-Network Benefits
You may also get Outpatient 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. In accordance with Minnesota Statute 62Q.481, your cost for a Prescription Drug used to treat diabetes, asthma or allergies that require the use of epinephrine auto-injectors will not exceed $50 for a three-month supply. 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, after the Deductible. Charges are based on the Usual and Customary Charge.

Oral chemotherapy Drugs

Network Benefits	Out-of-Network Benefits
90% of the Charges incurred. For Network Benefits, oral chemotherapy Drugs must be obtained from a Designated Vendor. In accordance with Minnesota Statute 62A.3075, orally administered anticancer medications are not subject to a higher Deductible, Copayment or Coinsurance than intravenously administered or injectable cancer medications.	80% of the Charges incurred, after the Deductible. Charges are based on the Usual and Customary Charge.

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, after the Deductible. Charges are based on the Usual and Customary Charge.

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.

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, after the Deductible. Charges are based on the Usual and Customary Charge.

Contraceptive Drugs

Network Benefits	Out-of-Network Benefits
Formulary Drugs: 100% of the Charges incurred. 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, after the Deductible. Charges are based on the Usual and Customary Charge.

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. Charges are based on the Usual and Customary Charge.

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 signing in to your HealthPartners online account.
- 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 six 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 covered 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 indicated 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 and eligible for coverage 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 and other Drugs when used for weight loss, even if used for a non-cosmetic purpose (i.e., morbid obesity)
- 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 and indications 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
- Costs above the pharmacy's Charge or contracted rate when manual claims are submitted
- Non-Formulary Drugs, unless a Formulary exception has been granted through the Formulary exception process

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

Sign in to your HealthPartners online account 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. Charges are based on the Usual and Customary Charge.

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 eleven child health supervision visits from birth to 36 months and once a year from 36 months to 72 months.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred.	100% of the Charges incurred. Deductible does not apply. Charges are based on the Usual and Customary Charge.

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. Charges are based on the Usual and Customary Charge.

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, after the Deductible. Charges are based on the Usual and Customary Charge.

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. Charges are based on the Usual and Customary Charge.

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 ACIP (available at cdc.gov/vaccines). Immunizations for travel and non-routine immunizations (e.g., rabies) are covered when Medically Necessary under the "Outpatient Professionally Administered Injections and Infusions" benefit.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred.	100% of the Charges incurred. Deductible does not apply. Charges are based on the Usual and Customary Charge.

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 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. Charges are based on the Usual and Customary Charge.

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. Charges are based on the Usual and Customary Charge.

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. Charges are based on the Usual and Customary Charge.

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 FDA or by the National Cancer Institute.

Network Benefits	Out-of-Network Benefits
Coverage level is same as corresponding Network Benefits depending on the 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 the 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.

RAPID WHOLE GENOME SEQUENCING AS REQUIRED UNDER MN STATUTE 62A.3098

Definitions:

Rapid Whole Genome Sequencing (rWGS). This is an investigation of the entire human genome, including coding and noncoding regions and mitochondrial deoxyribonucleic acid, to identify disease-causing genetic changes that returns the final results in 14 days. Rapid whole genome sequencing includes patient-only whole genome sequencing and duo and trio whole genome sequencing of the patient and the patient's biological parent or parents.

Covered Services:

We cover Rapid Whole Genome Sequencing when all of the following are met:

- The Insured is age 21 or younger
- The Insured has a complex or acute illness of unknown origin that has been confirmed to not be caused by an environmental exposure, toxic ingestion, infection with a normal response to therapy or a trauma
- The Insured is receiving Inpatient Hospital services in an intensive care unit or a neonatal or high acuity pediatric care unit

In addition, all of the following must be true about the Insured's condition:

- The Insured has symptoms that suggest a broad differential diagnosis that would require an evaluation by multiple genetic tests if rWGS testing is not performed;
- Timely identification of a molecular diagnosis is necessary in order to guide clinical decision making, and the rWGS testing may aid in guiding the treatment or management of the Insured's condition; and
- The Insured's complex or acute illness of unknown etiology includes at least one of the following conditions:
  - Congenital anomalies involving at least two organ systems, or complex or multiple congenital anomalies in one organ system
  - Specific organ malformations that are highly suggestive of a genetic etiology
  - Abnormal laboratory tests or abnormal chemistry profiles suggesting the presence of a genetic disease, complex metabolic disorder, or inborn error of metabolism
  - Refractory or severe hypoglycemia or hyperglycemia
  - Abnormal response to therapy related to an underlying medical condition affecting vital organs or bodily systems
  - Severe muscle weakness, rigidity, or spasticity
  - Refractory seizures

- A high-risk stratification on evaluation for a brief resolved unexplained event with any of the following features:
  - A recurrent event without respiratory infection
  - A recurrent seizure-like event
  - A recurrent cardiopulmonary resuscitation
- Abnormal cardiac diagnostic testing results that are suggestive of possible channelopathies, arrhythmias, cardiomyopathies, myocarditis, or structural heart disease
- Abnormal diagnostic imaging studies that are suggestive of underlying genetic condition
- Abnormal physiologic function studies that are suggestive of an underlying genetic etiology
- Family genetic history related to the patient's condition

Network Benefits	Out-of-Network Benefits
Coverage level is same as corresponding Network Benefits, such as Laboratory Services or Inpatient Hospital services.	Coverage level is same as corresponding Out-of-Network Benefits, such as Laboratory Services or Inpatient Hospital services.

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

Note: If HealthPartners does not have a contract with the Out-of-Network Provider, the determination of eligible Charges will be based on the Provider's established rate for uninsured patients for that service. If the Provider does not have an established rate for uninsured patients, the determination of eligible Charges will be based on the average commercial insurance rate that HealthPartners has paid for that service in the state where the service is provided over the past 12 months. If HealthPartners has not paid for that service in that state in the past 12 months, then the Charge will be based on the lesser of the average rate HealthPartners has paid for that service across all states over the past 12 months or the Provider's standard charge. If the Provider is outside the state of Minnesota, the Provider may not consider the payment in full and could bill you for any amounts above your Copayment or Coinsurance.

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 the type of service provided, such as Office Visits for Illness or Injury.	See Network coverage for the services covered.

TELEHEALTH/TELEMEDICINE SERVICES

Definitions:

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.

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.

Telemonitoring Services. This means the remote monitoring of clinical data related to the patient'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.

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

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

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.

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.

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, after the Deductible. Charges are based on the Usual and Customary Charge.

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, after the Deductible. Charges are based on the Usual and Customary Charge.

Video Visits

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.

TERMINATION OF PREGNANCY

Covered Services:

We cover abortion and abortion-related services, including pre-abortion services and follow-up services.

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.

TRANSPLANT SERVICES

Definitions:

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 in our Coverage Criteria Policies, 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.

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.

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

We cover eligible Transplant Services (as defined above) while you are covered under the Certificate. Coverage is limited to Medically Necessary, non-experimental transplants.

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.

Sign in to your HealthPartners online account 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, after the Deductible. Charges are based on the Usual and Customary Charge. Out-of-Network Benefits for transplant surgery do not apply to the Out-of-Pocket Limit.

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.

You will need to submit a Travel Benefit Claim Form and related receipts of services to receive reimbursement for eligible travel and lodging expenses. Sign in to your HealthPartners online account or call Member Services to access the Travel Benefit Claim Form or to determine if additional Coverage Criteria Policies apply.

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.

Sign in to your HealthPartners online account 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 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. Out-of-Network Benefits for bariatric surgery do not apply to the Out-of-Pocket Limit.

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. Sign in to your HealthPartners online 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
- For accident-related dental services, the cost of dental implants and any associated procedures (including bone grafting, implant placement and restoration) in excess of the amount that would be paid toward the fabrication of a removable dental prosthesis
- Oral surgery to remove wisdom teeth

Investigative services

We do not cover the use of any item or service we determine is Investigational 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 Investigational or Experimental 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 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) for cosmetic purposes, including androgenic alopecia (pattern baldness). This does not apply to wigs for hair loss resulting from a health condition as described in the "Durable Medical Equipment, Prostheses, Orthoses and Supplies" section.

Providers/Network

- Network Benefits for services received from Out-of-Network Providers*
- 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
- Non-emergent Health Care Services delivered or items supplied from providers located outside of the United States or US Territories. Emergency Services from non-US providers and post-stabilization services rendered as part of the visit during which the emergency room services were provided will be covered as Out-of-Network Benefits.

*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
- Compensation fees for surrogates/gestational carriers
- 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. This exclusion does not apply to appropriate orthoses and prostheses used for physical activities as determined by a Provider and described in the "Durable Medical Equipment, Prostheses, Orthoses and Supplies" section.
- 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 sign in to your HealthPartners online account 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, except as specifically described in the "Behavioral Health Services" section
- 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

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 and other Drugs when used for weight loss, even if used for a non-cosmetic purpose (i.e., morbid obesity)

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, (except those included on the Over-the Counter Drug Program list) 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
- Prepaid programs and services, including concierge programs
- 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:
HealthPartners follows Federal and State civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of their race, color, national origin, age, disability or sex.

- We provide reasonable modifications to help people with disabilities 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 nondiscrimination policy:
Contact the Civil Rights Coordinator at 1-844-363-8732 or integrityandcompliance@healthpartners.com.
View this notice on our website at 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. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-883-2177 (TTY: 711) o hable con su proveedor.

Polski *(Polish)*

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-883-2177 (TTY: 711) lub porozmawiaj ze swoim dostawcą.

Deutsch *(German)*

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-883-2177 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

العربية *(Arabic)*

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-883-2177 (TTY: 711) أو تحدث إلى مقدم الخدمة.

Lus Hmoob *(Hmong)*

LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-800-883-2177 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

中文 *(Traditional Chinese)*

注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-883-2177 (TTY: 711) 或與您的提供者討論。

Additional languages listed on page 2

Tagalog *(Tagalog)*

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-883-2177 (TTY: 711) o makipag-usap sa iyong provider.

Français *(French)*

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-883-2177 (TTY: 711) ou parlez à votre fournisseur.

Soomaali *(Somali)*

FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-800-883-2177 (TTY: 711) ama la hadal bixiyahaaga.

اردو *(Urdu)*

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 1-800-883-2177 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

हिंदी *(Hindi)*

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-883-2177 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

РУССКИЙ *(Russian)*

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-883-2177 (TTY: 711) или обратитесь к своему поставщику услуг.

Việt *(Vietnamese)*

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-883-2177 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

ગુજરાતી *(Gujarati)*

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓક્ઝિલરી સહાય અને એક્સેસિબલ ફોરમેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-883-2177 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

한국어 *(Korean)*

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-883-2177 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Afaan Oromoo *(Oromo)*

Hubachiisa: Yoo Afaan Oromo dubbatan, tajaajili gargaarsa afaan hiikuu tolaan ni jira. Gargaasi akkaan gaarii fi tajaajiloni kan biroo odeefannoo ittiin argatanis kafalttii malee ni kennamu. Lakkoofsa kanaan bilbilaa 1-800-883-2177 (TTY: 711) ykn Kan isin tajaajilan waliin haasawaa.

ထၢၵ်ိာလီၤဖဲအံၤ *(Karen)*

ဆူ- နမ့ၢ်ကတိၤ ထၢၵ်ိာလီၤဖဲအံၤ အဃီ, တ်ၢအိဉ်ဒီး ကျိာ်တ်ၢ ဆိဉ်ထွဲမၤစၢၤ လၢတ့လာ် ဘူဉ်လာ်စုၤလၢၵ်ိာလီၤ. တ်ၢ အိဉ်ဒီး တ်ၢမၤစၢၤတ်ၢၵ်ိာဟူပ်ီးလဲဒီး တ်ၢမၤစၢၤတ်ၢမၤ လၢအ ကပြုးအဘဉ် လၢကဟ့ဉ်တ်ၢဂ့ၢ်တ်ၢကျိၤ လ့ၢတ်ၢမၤၵ်ိာအံၤ သတဖဉ် လၢတလာ်ဘူဉ်လာ်စုၤ လၢၵ်ိာလီၤ. ကိး 1-800-883-2177 (TTY: 711) မ့တ်မ့ၢ် ကတိၤတၢ်ဒီး နပှၤလၢဟ့ဉ် နၤ တ်ၢကွၢ်ထွဲမၤစၢၤတက့ၢ်.

አማርኛ *(Amharic)*

ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-800-883-2177 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

తెలుగు *(Telugu)*

నావధానం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెసిబుల్ ఫార్మాట్లలో సమాచారాన్ని అర్థం చేసుకోవడానికి తగిన సహాయక సహాయాలు మర్యు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 1-800-883-2177 (TTY: 711) కి కాల్ చేయండి లేదా మీ ప్రొవైడర్తో మాట్లాడండి.

Kiswahili *(Swahili)*

MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-800-883-2177 (TTY: 711) au zungumza na mtoa huduma wako.