HealthPartners Insurance Company
Wisconsin Individual Cost Share Reduction Plan
Silver
Benefits Chart

UNDERSTANDING YOUR COVERAGE

This Benefits Chart is the part of the Individual Policy (Policy) that explains how much you will pay for Medically Necessary or Dentally Necessary services. Covered Services are based on the conditions, limitations and exclusions in this Benefits Chart, other sections of the Policy, our Medical Policies and your drug Formulary.

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

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

This is a Federally Qualified Health Plan.

Benefits are underwritten by HealthPartners Insurance Company.

Your Policy is subject to plan and benefit changes required to maintain compliance with federal and state law. This includes, but is not limited to, benefit changes required to maintain a certain actuarial value or metal level. We also may change your Deductible, Copayment, Coinsurance, and Out-of-Pocket Limit values on an annual basis to reflect cost of living increases.

Your Policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

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 Policy.

HOW YOUR CHOICE OF PROVIDERS AFFECTS YOUR COVERAGE

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

Coverage may also vary depending on whether you are receiving services from a Network Primary Care Provider, or from a Network Specialty Care Provider.

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

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

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

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 your Policy.

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

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

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

The usual and customary charge is the maximum amount allowed that we consider in the calculation of the payment of charges incurred for certain Covered Services. You may be liable for any charges above the usual and customary charge, and they do not apply to the Deductible or Out-of-Pocket Limit.

The usual and customary charge is determined using one of the following options in the following order, depending on availability: 1) a percentage of the Medicare fee schedule; 2) a comparable schedule if the service is not on the Medicare fee schedule; or 3) a commercially reasonable rate for such service.

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

To be covered, a charge must be incurred on or after your effective date and on or before the termination date.

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

Copayment/Coinsurance. The specified dollar amount, or percentage, of Charges incurred for Covered Services, which we do not pay, but which you must pay, each time you receive certain 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. This is 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 Calendar Year. Our payment for those services or items begins after the deductible is satisfied. An individual's Copayments and Coinsurance do not apply toward the family deductible. For Network Providers, the amount of the Charges that apply to the deductible are based on the Network Provider's discounted Charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule rate for case rate or withhold arrangements. For Out-of-Network Providers, the amount of Charges that apply to the deductible are the lesser of the Provider's Charges or the usual and customary charge for a service.

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

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

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

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

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

Investigative or Experimental. As determined by us, a drug, device, medical, behavioral health or dental treatment is investigative 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 a drug or device can be lawfully marketed for its proposed use by the United States Food and Drug Administration (FDA).
- The drug or device, or medical, behavioral health or dental treatment or procedure is not the subject of ongoing Phase I, II or III clinical trials
- 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
- There is conclusive evidence in major peer-reviewed medical journals demonstrating the safety, effectiveness and positive effect on health outcomes (the beneficial effects outweigh any harmful effects) of the service or treatment when compared to standard established service or treatment. Each article must be of well-designed investigations, using generally acceptable scientific standards that have been produced by nonaffiliated, authoritative sources with measurable results. Case reports do not satisfy this criterion. This also includes consideration of whether a drug is included in one of the standard reference compendia or "Major Peer Reviewed Medical Literature" (defined below) for use in the determination of a Medically Necessary accepted indication of drugs and biologicals used off-label as appropriate for its proposed use.

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

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 and Prescription Drug use that are appropriate in terms of type, frequency, level, setting and duration to your diagnosis or condition, diagnostic testing and preventive services. Medically necessary care, as determined by us must be:

- Appropriate for the symptoms, diagnosis or treatment of your medical condition
- Consistent with evidence-based standards of medical practice where applicable

- Not primarily for your convenience or that of your family, your Physician, or any other person
- The most appropriate and cost-effective level of medical services, Prescription Drugs or supplies that can be safely provided. When applied to Inpatient care, it further means that the medical symptoms or conditions require that the medical services, Prescription Drugs or supplies cannot be safely provided in a lower level of care setting.

The fact that a Physician, participating provider, or any other provider, has prescribed, ordered, recommended or approved a treatment, service, Prescription Drug or supply, or has informed you of its availability, does not in itself make it medically necessary.

Out-of-Pocket Expenses. You pay the specified Copayments/Coinsurance and Deductibles applicable for particular services, subject to the Out-of-Pocket Limit described below. These amounts are in addition to the monthly premium payments.

Out-of-Pocket Limit. You pay the Copayments/Coinsurance and Deductibles for Covered Services, to the individual or family out-of-pocket limit. Thereafter we cover 100% of Charges incurred for all other Covered Services, for the rest of the Calendar Year. You pay amounts greater than the out-of-pocket limit if you exceed any lifetime maximum benefit or any visit or day limits.

Out-of-Network Expenses do not apply toward the Network Out-of-Pocket Limit. This does not include services covered under Network Benefits when received by Out-of-Network Providers as required by the No Surprises Act.

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

You are responsible to keep track of the Out-of-Pocket Expenses. Contact our Member Services Department for assistance in determining the amount paid by the Enrollee for specific eligible services received. Claims for reimbursement under the out-of-pocket limit provisions are subject to the same time limits and provisions described under the "Claims Provisions" section of your Policy.

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

Primary Care Providers. These are Providers in the following categories: Family Practice, General Practice, Internal Medicine, Pediatrics, Adolescent Medicine, Adult Medicine and Geriatrics.

Specialty Care Providers. These are Providers who are not in the following categories: Family Practice, General Practice, Internal Medicine, Pediatrics, Adolescent Medicine, Adult Medicine and Geriatrics.

DEDUCTIBLES AND OUT-OF-POCKET LIMITS

Individual Calendar Year Deductible

Network Benefits	Out-of-Network Benefits
$5,700	$20,000

Family Calendar Year Deductible

Network Benefits	Out-of-Network Benefits
$11,400	$40,000

Your individual and family Deductible amounts may be indexed to allow for changes under federal rules.

Your plan has an embedded Deductible. This means that 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 amount towards the family Deductible.

Separate Deductibles must be satisfied under the Network Benefits and Out-of-Network Benefits.

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

Individual Calendar Year Out-of-Pocket Limit

Network Benefits	Out-of-Network Benefits
$7,200	None.

Family Calendar Year Out-of-Pocket Limit

Network Benefits	Out-of-Network Benefits
$14,400	None.

Out-of-Network Expenses do not apply toward the Network Out-of-Pocket Limit. This does not include services covered under Network Benefits when received by Out-of-Network Providers as required by the No Surprises Act.

Your individual and family Out-of-Pocket amounts may be indexed to allow for changes under federal rules.

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 Policy, 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.

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 medical Coverage Criteria.

Non-emergency fixed wing air ambulance requires prior authorization.

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

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

Network Benefits	**Out-of-Network Benefits**
60% of the Charges incurred.	See Network Benefits. The amount you pay for air ambulance services will be determined based on the requirements of the No Surprises Act and its implementing regulations.

AUTISM SERVICES

Covered Services:

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

Your Network Provider will coordinate the prior authorization process for any autism treatment services. You may call Member Services at 952-883-5900 or toll-free at 888-360-0622 if you have any questions or concerns regarding the authorization process.

Please call Member Services at 952-883-5900 or toll-free at 888-360-0622 to request authorization for autism treatment services from an Out-of-Network Provider.

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

Intensive-level services for children diagnosed with autism spectrum disorders. Intensive-level services must begin on or after 2 years of age and end before 9 years of age. Intensive-level services, on average, are services provided for more than 20 hours of treatment per week. (The average number of hours a week is calculated over a six month period.) Intensive level services under Network and Out-of-Network Benefits combined will be covered for up to four cumulative years under this plan or any other plan.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $40 per visit. Deductible does not apply. Limited to 240 visits per Calendar Year.	50% of the Charges incurred. Limited to 240 visits per Calendar Year.

The maximum number of visits is combined for Network Benefits and Out-of-Network Benefits. Visit limits are based on the minimum coverage amount available at the time of publication. Additional visits may be available if required due to revised minimum coverage amounts issued by the Office of the Commissioner of Insurance. See our medical coverage criteria for current visit limits.

Non-intensive-level services for Insureds diagnosed with autism spectrum disorders

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $40 per visit. Deductible does not apply. Limited to 120 visits per Calendar Year.	50% of the Charges incurred. Limited to 120 visits per Calendar Year.

The maximum number of visits is combined for Network Benefits and Out-of-Network Benefits. Visit limits are based on the minimum coverage amount available at the time of publication. Additional visits may be available if required due to revised minimum coverage amounts issued by the Office of the Commissioner of Insurance. See our medical coverage criteria for current visit limits.

Not Covered:

- Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders that are not evidence based

BEHAVIORAL HEALTH SERVICES

Definitions:

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

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

Covered Services:

Transitional treatment services. These are services for the treatment of nervous or mental disorders, and substance use disorders which are provided to an Insured in a less restrictive manner than are Inpatient Hospital services but in a more intensive manner than are Outpatient services. Transitional treatment services are services offered by a provider, and certified by the Wisconsin Department of Health Services for each of the following (except the last bulleted item):

- Mental health services for covered adults in a day treatment program
- Mental health services for covered children in a day Hospital treatment program
- Services for persons with chronic mental Illness provided through a community support program
- Residential treatment programs for covered persons with substance use disorder

- Substance use disorder services in a day treatment program
- Services for persons who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided
- Intensive Outpatient programs for the treatment of psychoactive substance use disorders provided in accordance with the patient placement criteria of the American Society of Addiction Medicine

Mental health services

We cover services for mental health diagnoses as described in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM 5) (most recent edition). Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services to determine if additional Coverage Criteria Policies apply.

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

Outpatient services: We cover Medically Necessary Outpatient professional mental health services for evaluation, crisis intervention, and treatment of mental health disorders.

A comprehensive diagnostic assessment will be 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
- Partial hospitalization services in a licensed Hospital or community mental health center
- Psychotherapy and nursing services provided in the home
- Treatment for gender dysphoria

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

Network Benefits	**Out-of-Network Benefits**
100% of the Charges incurred, subject to a Copayment of $40 per visit. Deductible does not apply. For family therapy, only one Copayment will be Charged, regardless of the number of Insureds primarily involved in the therapy.	50% of the Charges incurred.

Group therapy

Network Benefits	**Out-of-Network Benefits**
100% of the Charges incurred, subject to a Copayment of $20 per visit. Deductible does not apply.	50% of the Charges incurred.

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

- Medically Necessary Inpatient services in a Hospital and professional services for treatment of mental health disorders. Medical stabilization is covered under Inpatient Hospital services in the "Hospital and Skilled Nursing Facility Services" section.
- Medically Necessary mental health residential treatment service. This care must be authorized by us and provided by a Hospital or Residential Behavioral Health Treatment Facility licensed by the local state or Department of Health and Human Services. Services not covered under this benefit include halfway houses, group homes, extended care facilities, shelter services, correctional services, detention services, housing support programs, foster care services, and wilderness and outdoor programs.

Network Benefits	**Out-of-Network Benefits**
60% of the Charges incurred.	50% of the Charges incurred.

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

Network Benefits	**Out-of-Network Benefits**
100% of the Charges incurred, subject to a Copayment of $40 per visit. Deductible does not apply.	50% of the Charges incurred.

Substance use disorder (SUD) treatment services

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

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

Outpatient services we cover for a diagnosed substance use disorder include the following:
- Individual, group, family, and multi-family therapy provided in an office setting
- Opiate replacement therapy including methadone and buprenorphine treatment

Network Benefits	**Out-of-Network Benefits**
100% of the Charges incurred, subject to a Copayment of $40 per visit. Deductible does not apply.	50% of the Charges incurred.

Inpatient services: We cover the following:

- Medically Necessary Inpatient services in a Hospital or a licensed residential primary treatment center
- 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 Services

Network Benefits	**Out-of-Network Benefits**
60% of the Charges incurred.	50% of the Charges incurred.

Transitional treatment services: We cover transitional treatment services described above for treatment of substance use disorder.

Network Benefits	**Out-of-Network Benefits**
100% of the Charges incurred, subject to a Copayment of $40 per visit. Deductible does not apply.	50% of the Charges incurred.

Out of area services for Wisconsin students: If a dependent child is a student in a school located in Wisconsin, but outside of our service area, we cover mental health and substance use disorder services as required under Wisconsin Statute 609.655.

- The student may have a clinical assessment from a local, Out-of-Network mental health or substance use disorder treatment provider at the Network benefit level when prior authorized by us
- If Outpatient services are recommended in the clinical assessment, five Outpatient visits from an Out-of-Network provider will be covered at the Network benefit level
- Our Medical Director will determine the need for continuing treatment by the Out-of-Network provider; additional visits may be approved
- Coverage for the Outpatient services will not be provided if the recommended treatment would keep the student from attending school on a regular basis or if the student is no longer attending the school full-time

This benefit is subject to the limitations shown in this "Behavioral Health Services" section.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $40 per visit. Deductible does not apply.	Not applicable.

A dependent child enrolled in a school outside of the state of Wisconsin is not eligible for the benefit.

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 and any comparable facilities, services or programs
- Correctional services and detention services
- Wilderness and outdoor programs even when the program is through a licensed Facility
- Animal therapy, including hippotherapy and equine therapy
- Religious counseling
- Marital/relationship counseling
- Sex therapy
- Professional services associated with substance use disorder interventions. A "substance use disorder intervention" is a gathering of family and/or friends to encourage an Insured to seek substance use disorder treatment.

CHIROPRACTIC SERVICES

Covered Services:

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

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

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

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $80 per visit. Deductible does not apply.	50% of the Charges incurred.

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 approved clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition as defined in the Affordable Care Act. Approved clinical trials include (1) federally funded trials when the study or investigation is approved or funded by any of the federal agencies defined in the Public Health Services Act, section 2709 (d) (1) (A); (2) the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; and (3) the study or investigation is a drug trial that is exempt from having such an investigational new drug application. We cover routine patient costs for services that would be eligible under the Policy and this Benefits Chart if the service were provided outside of a clinical trial.

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

Network Benefits	Out-of-Network Benefits
Coverage level is same as corresponding Network Benefits depending on 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 or experimental item, device or service itself
- Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

DENTAL SERVICES

Covered Services:

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

Accidental dental services. We cover Dentally Necessary services to treat and restore damage done to sound, natural, unrestored teeth as a result of an accidental Injury. Dentally Necessary care is limited to diagnostic testing, treatment and the use of dental equipment and appliances which in the judgement of a dentist is required to prevent deterioration of dental health, or restore dental function. Your general health must permit the necessary procedure(s). Coverage is for damage caused by external trauma to face and mouth only, not for cracked or broken teeth, which result from biting, chewing, clenching or grinding of teeth. We cover restorations, root canals, crowns and replacement of teeth lost that are directly related to the accident in which the Insured was involved. We cover initial exams, x-rays and palliative treatment including extractions, and other oral surgical procedures directly related to the accident. Subsequent treatment must be initiated within the specified time-frame and must be directly related to the accident. We do not cover restoration and replacement of teeth that are not "sound and natural" at the time of the accident.

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

When an implant-supported dental prosthetic treatment is pursued, benefits are limited to the amount that would be paid toward the placement of a removable dental prosthetic appliance that could be used in the absence of implant treatment. Implants must be prior authorized and provided by a Network Provider.

Services received in an emergency department are covered under the "Emergency and Urgently Needed Care Services" section.

Network Benefits	Out-of-Network Benefits
60% of the Charges incurred.	No coverage.

For all accidental dental services, treatment and/or restoration must be initiated within six months of the date of the Injury. Coverage is limited to the initial course of treatment and/or initial restoration. Services must be provided within 24 months of the date of Injury to be covered.

Medical referral dental services

Medically Necessary Outpatient dental services. We cover Medically Necessary Outpatient dental services. Coverage is limited to dental services required for treatment of an underlying medical condition, e.g., removal of teeth to complete radiation treatment for cancer of the jaw, cysts and lesions.

Network Benefits	Out-of-Network Benefits
60% of the Charges incurred.	50% of the Charges incurred.

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

- Children age 4 or younger
- Pediatric dental patients when care in dental offices has been attempted unsuccessfully and usual methods of behavior modification have not been successful, or when extensive amounts of restorative care, exceeding four appointments, are required
- Insureds who are severely psychologically impaired or developmentally disabled, regardless of age
- Insureds who have a serious underlying medical condition, regardless of age, for whom dental treatment would create significant or undue medical risks if not completed in a Hospital or ambulatory surgery center
- Extensive procedures which prevent an oral surgeon from providing general anesthesia in the office, regardless of age

Anesthesia is covered in a Hospital or a dental office. The following are examples, though not all-inclusive, of medical conditions which may require hospitalization for dental services: severe asthma, severe airway obstruction or hemophilia. Except as described above, hospitalization required due to the behavior of the Insured or due to the extent of the dental procedure is not covered.

The requirement of a Hospital setting must be due to an Insured's underlying medical condition. Coverage is limited to Facility and anesthesia Charges. Oral surgeon/dentist professional fees are not covered.

Network Benefits	Out-of-Network Benefits
60% of the Charges incurred.	50% of the Charges incurred.

Medical complications of dental care. We cover medical complications of dental care. Treatment must be Medically Necessary Care and related to medical complications of non-covered dental care, including complications of the head, neck, or substructures.

Network Benefits	Out-of-Network Benefits
60% of the Charges incurred.	50% of the Charges incurred.

Oral surgery. Coverage is limited to treatment of medical conditions requiring oral surgery, such as treatment of oral neoplasm, non-dental cysts, fracture of the 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
60% of the Charges incurred.	50% of the Charges incurred.

Treatment of cleft lip and cleft palate. We cover treatment of cleft lip and cleft palate including orthodontic treatment and oral surgery directly related to the cleft. If the Insured covered under your Policy 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
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.

Treatment of temporomandibular disorder (TMD) and craniomandibular disorder (CMD). We cover diagnostic procedures, surgical treatment and non-surgical treatment (including intraoral splint therapy devices) for TMD and CMD. Services must be Medically Necessary and administered or prescribed by a Physician or dentist. Oral appliances are subject to the same Coinsurance, conditions and limitations as durable medical equipment. Dental services which are not required to directly treat TMD or CMD are not covered.

Network Benefits	Out-of-Network Benefits
60% of the Charges incurred.	50% of the Charges incurred.

Not Covered:

- Dental treatment, procedures or services not described above
- Accident-related dental services when any of the following is true about your treatment:
  - Provided to teeth which are not: sound, natural and unrestored
  - Initiated beyond six months from the date of the Injury, unless extenuating circumstances exist
  - Received beyond the initial treatment or restoration
  - Received beyond 24 months from the date of Injury
- Accident-related dental services by an Out-of-Network Provider
- Oral surgery to remove wisdom teeth
- Orthognathic treatment or procedures and all related services unless required to treat TMD, CMD and it meets our Medical Coverage Criteria

DIABETIC EQUIPMENT AND SUPPLIES

Covered Services:

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

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

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

Network Benefits	Out-of-Network Benefits
60% of the Charges incurred.	50% of the Charges incurred.

All other diabetic 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
60% of the Charges incurred.	50% of the Charges incurred.

Limitations:

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

Not Covered:

- Replacement or repair of any covered items, if the items are damaged or destroyed by misuse, abuse or carelessness, lost or stolen
- Duplicate or similar items
- Labor and related charges for repair of any covered items which are more than the cost of replacement by an approved vendor
- Batteries for monitors and equipment
- Sales tax, mailing, delivery charges and service call charges

DIAGNOSTIC IMAGING SERVICES

Covered Services:

This benefit applies to diagnostic imaging, when 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
60% of the Charges incurred.	50% of the Charges incurred.

All other Outpatient diagnostic imaging services

Services for Illness or Injury

Network Benefits	Out-of-Network Benefits
60% of the Charges incurred.	50% of the Charges incurred.

Preventive services (MRI/CT procedures are not considered preventive)

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

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

Covered Services:

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

- Durable medical equipment, such as wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices, Hospital beds and related services
- Prosthetics, including breast prostheses, artificial limbs and artificial eyes (including polishing and adjustments), and related supplies
- Orthotics
- Cochlear implants, including implant batteries and replacement of external parts
- Medical supplies, including splints, surgical stockings, casts and dressings
- Enteral feedings
- Special dietary treatment for phenylketonuria (PKU) and oral amino acid based elemental formula if it is recommended by a Physician

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

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

Network Benefits	Out-of-Network Benefits
60% of the Charges incurred.	50% of the Charges incurred.

Oral amino acid based elemental formula

Network Benefits	Out-of-Network Benefits
60% of the Charges incurred.	50% of the Charges incurred.

All other durable medical equipment, prosthetics, orthotics and supplies

Network Benefits	Out-of-Network Benefits
60% of the Charges incurred.	50% of the Charges incurred.

Limitations:

Coverage of durable medical equipment is limited by the following.

- No more than a 90-day supply of special dietary treatment for phenylketonuria and oral amino acid based elemental formula is covered and dispensed at a time
- 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 oral appliances for cleft lip and cleft palate.
- We reserve the right to determine if an item will be approved for rental vs. purchase
- Durable medical equipment and supplies must be obtained from or repaired by approved vendors

Not Covered:

Items which are not eligible for coverage include, but are not limited to:

- Replacement or repair of any covered items, if the items are damaged or destroyed by misuse, abuse or carelessness, lost or stolen
- Duplicate or similar items, including replacement or repair of duplicate or similar item
- Labor and related charges for repair of any covered items which are more than the cost of replacement by an approved vendor
- Charges for repair estimates, sales tax billed separately, mailing, delivery charges and service call charges
- Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience, recreation or safety
- 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” or “Pediatric Eyewear” sections
- Hair prostheses (wigs)
- 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, wiring, plumbing or charges for installation of equipment
- Vehicle, car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier.
- Rental equipment while owned equipment is being repaired by non-contracted vendors, beyond one month rental of Medically Necessary equipment
- Other equipment and supplies, including, but not limited to assistive devices, that we determine are not eligible for coverage

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 that:

- Are required in order to prevent a serious deterioration in your health
- Cannot be delayed until the next available clinic or office hours

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

Services received via Video, E-visits or Telephone are covered under the "Telehealth/Telemedicine Services" section

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $60 per visit. Deductible does not apply.	50% of the Charges incurred.

Emergency care services. These are services to treat:

- The sudden, unexpected onset of Illness or Injury which, if left untreated or unattended until the next available clinic or office hours, would result in hospitalization
- 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.

When reviewing claims for coverage of emergency services, our medical director will take into consideration 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.

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.

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

Network Benefits	Out-of-Network Benefits
60% of the Charges incurred.	See Network Benefits. The amount you pay for these services will be determined based on the requirements of the No Surprises Act and its implementing regulations.

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

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

GENDER AFFIRMING CARE

Definitions:

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

Covered Services:

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

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

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

GENE THERAPY

Covered Services:

We cover Medically Necessary gene therapy treatment

Network Benefits	Out-of-Network Benefits
Coverage level is same as corresponding Network Benefits depending on 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. Log on to your "*my*HealthPartners" account at healthpartners.com or call Member Services for more information.

HEALTH EDUCATION

Covered Services:

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

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred. Deductible does not apply.	50% of the Charges incurred.

HEARING AIDS

Covered Services:

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

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

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

Network Benefits	Out-of-Network Benefits
60% of the Charges incurred.	50% of the Charges incurred.

Limitations:

- Coverage is limited to one basic, standard hearing aid for each ear every three years. The three-year limitation is calculated from the date the last hearing aid was purchased for a specific ear, regardless of whether the previous hearing aid was covered by this plan. 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-BASED COMPREHENSIVE HEALTH RISK ASSESSMENT

Covered Services:

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

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred. Deductible does not apply.	No coverage.

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 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 benefit.

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.

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

Home health services are eligible for coverage only when all of the following are met:

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

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

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

Primary Care Providers

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $40 per visit. Deductible does not apply.	No coverage.

Specialty Care Providers

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $80 per visit. Deductible does not apply.	No coverage.

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

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

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred. Deductible does not apply.	No coverage.

Each 24-hour visit (or shifts up to 24-hour visits) equals one visit and counts toward the Maximum visits for all other services shown below. Any visit that lasts less than 24 hours regardless of the length of the visit, will count as one visit toward the Maximum visits for all other services shown below. All visits must be Medically Necessary and benefit eligible.

Routine postnatal well child visits

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred. Deductible does not apply.	50% of the Charges incurred.

Maximum visits for palliative care:

If you are eligible to receive palliative care in the home and you are not homebound, there is a maximum of 12 visits per Calendar Year.

Maximum visits for all services other than palliative care:

Network Benefits	Out-of-Network Benefits
60 visits per Calendar Year.	No coverage.

Routine postnatal well child visits do not count toward the visit maximum.

Limitations:

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

Not Covered:

- Home health services provided as a substitute for a primary caregiver in the home or as relief (respite) for a primary caregiver in the home
- Services provided by family members or residents in your home
- Custodial or Maintenance Care. This includes all services and medical equipment provided for such care.
- Social worker visits
- Services that occur outside of the home
- Home Health Services by an Out-of-Network Provider
- 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 2 to 12 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.

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**
60% of the Charges incurred.	No coverage.

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

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

Not Covered:

- Home Hospice Services by an Out-of-Network Provider
- Rest and respite services, except as described above
- Custodial or Maintenance Care related to hospice services, whether provided in the home or in a nursing home. This includes all services and medical equipment provided for such care. Custodial Care related to hospice services refers to assistance in the activities of daily living and the care needed by a terminally ill patient which can be provided by a primary caregiver (i.e. family member or friend) who is responsible for the patient's home care.
- Any service not described above
- 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 Home Hospice 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.

Confinement. This is one continuous Skilled Nursing Facility stay for the same medical condition.

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 or illness of the involved part. Coverage for newborn children includes functional repair and restoration of congenital defects and birth abnormalities. A functional defect is one that interferes with normal body functioning.

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

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

Inpatient Hospital services: We cover the following medical or surgical services, for the treatment of acute Illness or Injury, which require the level of care only provided in an acute care Facility.

Inpatient Hospital services include: room and board; the use of operating or maternity delivery rooms; intensive care facilities; newborn nursery facilities; general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, Prescription Drugs or other medications administered during treatment, blood and blood products (unless replaced), and blood derivatives, and other diagnostic or treatment related Hospital services; Physician and other professional medical and surgical services provided while in the Hospital, including gender affirming (confirmation) surgery that meets criteria in our Coverage Criteria Policies.

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.

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 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**
60% of the Charges incurred.	50% of the Charges incurred.

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

Outpatient Hospital, ambulatory care or surgical Facility services: We cover the following medical and surgical services, for diagnosis or treatment of Illness or Injury on an Outpatient basis.

Outpatient services include: use of operating rooms, maternity delivery rooms or other Outpatient departments, rooms or facilities; and the following Outpatient services: general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, drugs administered during treatment, administration of Specialty Drugs, blood and blood products (unless replaced), and blood derivatives, and other diagnostic or treatment related Outpatient services; Physician and other professional medical and surgical services provided while an Outpatient, including colonoscopies, and gender affirming (confirmation) surgery that meets criteria in our Coverage Criteria Policies.

Network Benefits	**Out-of-Network Benefits**
60% of the Charges incurred.	50% of the Charges incurred.

To see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see benefits under "Diagnostic Imaging Services", "Laboratory Services" and "Physical Therapy, Occupational Therapy and Speech Therapy and Other Specified Therapies" in this Benefits Chart.

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

Network Benefits	Out-of-Network Benefits
60% of the Charges incurred. Limited to a 30 day maximum per confinement.	50% of the Charges incurred. Limited to a 30 day maximum per confinement.

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

Limitations:

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

Not Covered:

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

INFERTILITY DIAGNOSIS

Covered Services:

We cover the diagnosis of infertility. These services include diagnostic procedures and tests provided in connection with an infertility evaluation, office visits and consultations to diagnose infertility.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $80 per visit. Deductible does not apply.	50% of the Charges incurred.

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

Not Covered:

- Infertility/fertility treatment and procedures, including, but not limited to, office visits, laboratory services, diagnostic imaging services, and fertility drugs
- Reversal of sterilization
- Sperm, ova or embryo acquisition, retrieval or storage
- Surrogacy/gestational carrier compensation, service and fees
- Maternity services for a surrogate/gestational carrier not covered under this Benefits Chart
- See Reproductive and maternity care in "Services Not Covered"

LABORATORY SERVICES

Covered Services:

This benefit applies to laboratory services when ordered by a Provider and received in a clinic or Outpatient Hospital Facility.

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

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

Network Benefits	Out-of-Network Benefits
60% of the Charges incurred.	50% of the Charges incurred.

All other laboratory services

Services for Illness or Injury

Network Benefits	Out-of-Network Benefits
60% of the Charges incurred.	50% of the Charges incurred.

Preventive services

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

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.

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

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred. Deductible does not apply.	No coverage.

OFFICE VISITS FOR ILLNESS OR INJURY

Covered Services:

We cover the following:

- Professional medical and surgical services and related supplies of Physicians and other Health Care Providers, including biofeedback and administration of Specialty Drugs
- Blood and blood products (unless replaced) and blood derivatives
- Diagnosis and treatment of Illness or Injury to the eyes. Where contact or eyeglass lenses are prescribed as Medically Necessary for the post-operative 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.

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

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

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

Office visits

Primary Care Providers

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $40 per visit. Deductible does not apply.	50% of the Charges incurred.

Specialty Care Providers

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $80 per visit. Deductible does not apply.	50% of the Charges incurred.

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

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $20 per visit. Deductible does not apply.	50% of the Charges incurred.

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

Allergy injections

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $2 per date of service. Deductible does not apply.	50% of the Charges incurred.

All other injections

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $2 per date of service. Deductible does not apply.	50% of the Charges incurred.

Limitations:

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

Not Covered:

- Court ordered treatment, except as described in the "Behavioral Health Services" section. Any resulting court ordered treatment for mental health services will be subject to the Policy's requirement for medical necessity.
- 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. This exclusion does not apply to eyewear for children as described in the "Pediatric Eyewear" section.

PEDIATRIC EYEWEAR

Covered Services:

We cover pediatric eyewear for children.

Routine eye exams are covered under the "Preventive Services" section.

Network Benefits	Out-of-Network Benefits
60% of the Charges incurred.	No coverage.

Limitations:

- Coverage under this provision will continue until the end of the month in which the child turns age 19
- Limited to one of the following per Calendar Year:
  - one pair of eyeglasses including one set of prescription lenses, frames from our designated eyewear collection, and anti-scratch coating
  - one pair of non-disposable contact lenses
  - a one year supply of disposable contact lenses
- Contact lens fittings are limited to two per Calendar Year

Not Covered:

- Frames that are not included in the designated eyewear collection. However, one pair of lenses will be covered if an Insured chooses frames outside our designated eyewear collection
- More than one pair of lenses or frames or non-disposable contacts per Calendar Year, regardless of the reason. This includes replacement of eyeglasses or contact lenses due to loss, breakage, theft, or change in prescription.
- Safety glasses or goggles for sports or vocational reasons
- Upgrades including, but not limited to, UV protection and no-line multifocal lenses

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

Definitions:

Habilitative Care. Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

Rehabilitative Care. Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of Inpatient and/or Outpatient settings.

Covered Services:

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

- Medically Necessary Rehabilitative Care to correct the effects of Illness or Injury
- Habilitative Care rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development

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

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

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

Rehabilitative Care

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $40 per visit. Deductible does not apply. Physical, Occupational and Speech Therapy are limited to 20 visits each per Calendar Year.	50% of the Charges incurred. Physical, Occupational and Speech Therapy are limited to 20 visits each per Calendar Year.

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

- 20 visits per Calendar Year for pulmonary rehabilitation therapy
- 36 visits per Calendar Year for cardiac rehabilitation therapy
- 30 visits per Calendar Year for post-cochlear implant aural therapy
- 20 visits per Calendar Year for cognitive rehabilitation therapy

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

Habilitative Care

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $40 per visit. Deductible does not apply. Physical, Occupational and Speech Therapy are limited to 20 visits each per Calendar Year.	50% of the Charges incurred. Physical, Occupational and Speech Therapy are limited to 20 visits each per Calendar Year.

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

Not Covered:

- Massage therapy, except as described above
- Maintenance Care

PRESCRIPTION DRUGS

Definitions

Brand Name Drug. A Prescription Drug, approved by the Food and Drug Administration (FDA), that is manufactured, sold or licensed for sale under a trademark by a pharmaceutical company. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, Generic Drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired. A few brand name drugs may be covered at the Generic Drug benefit level if this is indicated on the Formulary.

Formulary. This is a current list, which may be revised from time to time, of Prescription Drugs, medications, equipment and supplies covered by us as indicated in this Benefits Chart which are covered at the highest benefit level. Some drugs on the Formulary may require prior authorization to be covered as formulary drugs. You may be granted an exception to the formulary for certain drugs. The Formulary, and information on drugs that require prior authorization, are available by calling Member Services or logging on to your "*my*HealthPartners" account at healthpartners.com.

Formulary Exception Process. If you are prescribed a drug that is not included on the Formulary and your Policy does not cover Non-Formulary Drugs, you, your designee or your prescribing Physician may request a review through our formulary exception process which includes external review. This process is described below.

- **Standard Exception Request.** If your Provider prescribes a drug that is not on our Formulary, you may submit a standard exception request. If you, your designee or your prescribing Provider submit a standard exception request, we must make our coverage determination and notify you within 72 hours of our receipt of the request. If we grant the exception to cover the drug, we are required to cover the drug for the duration of the prescription, including refills.

- **Expedited Exception Request.** If your Provider prescribes a drug that is not on our Formulary, you may submit an expedited exception request if there are exigent circumstances. Exigent circumstances exist when you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course using a Non-Formulary Drug. If you, your designee or your prescribing Provider submit an expedited exception request, we must make our coverage determination and notify you within 24 hours of our receipt of the request. If we grant the exception to cover the drug, we are required to cover the drug for the duration of the prescription, including refills. If we grant an exception based on exigent circumstances, we must cover the drug for the duration of the exigency.
- **External Review Exception Request.** If coverage of a drug is denied under a standard or expedited exception review request described above, you, your designee or your prescribing Provider may request an external review exception request. If the initial request was a standard exception request, we must notify you or your designee and the prescribing Provider of the coverage determination within 72 hours of our receipt of your request for external review. If the initial request was an expedited exception request, we must notify you or your designee and the prescribing Provider of the coverage determination within 24 hours of our receipt of your request for external review.

  If you are granted an exception after the external review exception request, we are required to cover the drug for the duration of the prescription, if the initial request was a standard exception request. If the initial request was an expedited exception request, we must provide coverage for the duration of the exigency.

Generic Drug. A Prescription Drug, approved by the Food and Drug Administration (FDA), that the FDA has determined is comparable to a Brand Name Drug product in dosage form, strength, route of administration, quality, intended use and documented bioequivalence. Generally, generic drugs cost less than Brand Name Drugs. Some Brand Name Drugs may be covered at the generic drug benefit level if this is indicated on the Formulary.

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

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

Prescription drugs include drugs for the treatment of HIV infection if the drug is approved by the FDA for the treatment of HIV infection or an Illness or medical condition arising from or related to HIV infection, including investigational or experimental drugs which are prescribed and administered in accordance with the treatment protocol approved for the Investigative or experimental new drug. For Network Benefits, these drugs are considered part of the Formulary.

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

Covered Services:

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

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

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 30-day supply, or portion thereof.

Outpatient drugs (except as specified below)

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $20 for Generic Formulary Drugs. Deductible does not apply. Preferred Brand Name Formulary Drugs are covered at 100% of the Charges incurred, subject to a Copayment of $40. Deductible does not apply. Non-Preferred Brand Name Formulary Drugs are covered at 100% of the Charges incurred, subject to a Copayment of $80. Deductible applies. In no event will your cost for a Formulary insulin drug exceed $25. Deductible does not apply to Formulary insulin drugs.	50% of the Charges incurred.

Oral chemotherapy drugs are Specialty Drugs. However, you pay the applicable Outpatient drug Copayment. As required by Wisconsin law, your maximum Copayment will not be more than $100 per prescription for a 30-day supply.

Mail order drugs

Network Benefits	Out-of-Network Benefits
For your convenience, you may also get up to a 90-day supply of 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 and Copayments shown in Outpatient Drugs above. Specialty Drugs are not available through the designated mail order service.	Mail order drugs are only available through the designated mail order service. See Network Benefits.

Specialty Drugs that are self-administered

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $350. For Network Benefits, Specialty Drugs must be obtained from a designated vendor.	No coverage.

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.

Oral chemotherapy drugs are Specialty Drugs. However, you pay the applicable Outpatient drug Copayment. As required by Wisconsin law, your maximum Copayment will not be more than $100 per prescription for a 30-day supply.

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

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred. Deductible does not apply.	50% of the Charges incurred.

Contraceptive drugs

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred for Formulary drugs. Deductible does not apply. If a Physician requests that a Non-Formulary contraceptive drug be dispensed as written, the drug will be covered at 100%, not subject to the Deductible.	50% of the Charges incurred.

ACA preventive medications. We cover preventive medications currently recommended by USPSTF with an A or B rating if they are prescribed by your medical Provider and they are listed on our 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. Deductible does not apply.	50% of the Charges incurred.

Limitations:

- Certain drugs may require prior authorization or have quantity limits. HealthPartners may require prior authorization for the drug and also the site where the drug will be provided. The Formulary and information on drugs with limitations are available by calling Member Services or logging on to your "*my*HealthPartners" account at healthpartners.com.
- Certain drugs may be subject to our trial drug program. The trial drug program applies to new prescriptions for certain drugs which have high toxicity, low tolerance, high costs and/or high potential for waste. Trial drugs are indicated on the Formulary. Your first three fills of a trial drug may be limited to less than a month supply. If the drug is well tolerated and effective, you will receive the remainder of your prescribed supply.
- Biosimilar drugs, regardless of interchangeability status, are not considered Generic Drugs and are not covered under the Generic Drug benefit. A biosimilar drug is a Prescription Drug that the FDA has determined is highly-similar to a biological Brand Name Drug. HealthPartners will review each biosimilar drug and establish Formulary, coverage and specialty designations.
- Only medical devices approved by the FDA and included on our Formulary are covered under the "Prescription Drugs" section. All other covered medical devices are generally submitted and reimbursed under your medical benefits
- If an Insured requests a Brand Name Drug when there is a generic equivalent, the Brand Name Drug will be covered up to the Charge that would apply to the Generic Drug, minus any required Copayment. If a Physician requests that a Brand Name Drug be dispensed as written, and we determine the Brand Name Drug is Medically Necessary, the drug will be paid at the Non-Preferred Brand Name Drug benefit.
- We may require Insureds to try Over-the-Counter (OTC) drug alternatives before approving more costly Formulary Prescription Drugs
- Unless otherwise specified in this Prescription Drugs section, you may receive up to a 30-day supply per prescription
- New prescriptions to treat certain chronic conditions are limited to a 30-day supply
- A 90-day supply will be covered and dispensed only at pharmacies that participate in our extended day supply program
- No more than a 30-day supply of Specialty Drugs will be covered and dispensed at a time unless it's a manufacturer supplied drug that cannot be split that supplies the Insured with more than a 30-day supply

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 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 Formulary drugs that are determined to be Medically Necessary
- Medical foods, unless listed on the Formulary and prescribed by a Physician or legally authorized Health Care Provider under applicable state and federal law
- Drugs used for the treatment of sexual dysfunction
- Growth deficiency drugs
- Fertility drugs
- Weight loss drugs
- Medical cannabis
- Drugs on the Excluded Drug List. The Excluded Drug List includes select drugs within a therapy class that are not eligible for coverage. This includes drugs that may be excluded for certain indications. The Excluded Drug List is available at healthpartners.com.
- Drugs that are newly approved by the FDA until they are reviewed and coverage is established by our Pharmacy and Therapeutics Committee
- Drugs that we determine are Investigative

PREVENTIVE SERVICES

Definitions:

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

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

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

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

ACA and state mandated preventive services are covered as follows:

Routine health exams and periodic health assessments. A Physician or Health Care Provider will counsel you as to how often health assessments are needed based on age, sex and health status. This includes screening and counseling for tobacco cessation and all FDA approved tobacco cessation medications including Over-the-Counter drugs (as shown in the "Prescription Drugs" section).

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred. Deductible does not apply.	50% of the Charges incurred.

Child health supervision services. This includes pediatric preventive services such as newborn screenings, appropriate immunizations, developmental assessments and laboratory services (including blood tests to detect lead exposure) appropriate to the age of the child from birth to 72 months, and appropriate immunizations for children age 18 or younger.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred. Deductible does not apply.	50% of the Charges incurred.

Routine prenatal care and exams

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred. Deductible does not apply.	50% of the Charges incurred.

Routine postnatal care. This includes health exams, assessments, education and counseling relating to the period immediately after childbirth.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred. Deductible does not apply.	50% of the Charges incurred.

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

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred. Deductible does not apply.	50% of the Charges incurred.

Routine eye and hearing exams for Insureds age 21 or younger

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred. Deductible does not apply.	50% of the Charges incurred.

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

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred. Deductible does not apply.	50% of the Charges incurred.

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

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

Women's preventive health services. This includes 2D and 3D mammograms, screenings for cervical cancer (pap smears), breast pumps, human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus (HIV), and all FDA approved contraceptive methods as prescribed by a doctor, sterilization procedures, education and counseling (see the "Prescription Drugs" section for coverage of oral contraceptive drugs). We also provide genetic screening for BRCA if someone in your family has the gene or you have a diagnosis of cancer.

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

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred. Deductible does not apply.	50% of the Charges incurred.

Obesity screening and management. We cover obesity screening and counseling for all ages during a routine preventive care exam. If you are age 18 or older and have a body mass index of 30 or more, we also cover intensive obesity management to help you lose weight. Your primary care doctor can coordinate these services.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred. Deductible does not apply.	50% of the Charges incurred.

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

Routine hearing exams for adults age 22 and older

Network Benefits	Out-of-Network Benefits
60% of the Charges incurred.	50% of the Charges incurred.

Eye exams for adults diagnosed with diabetes

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred. Deductible does not apply.	50% of the Charges incurred.

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

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

- Routine eye exams for children under age 22 are limited to one visit per year
- Services are not preventive if received as part of a visit to diagnose, manage or maintain an acute or chronic medical condition, Illness or Injury. When that occurs, unless otherwise indicated above, standard Deductibles, Copayments or Coinsurance apply.

Not Covered:

- Routine eye exams for adults age 22 and older

TELEHEALTH/TELEMEDICINE SERVICES

Definitions:

Telehealth, Telemedicine, or 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:

- Interactive audio or audio-video
- Interactive audio with store-and-forward technology
- Chat-based and email-based systems
- Physician-to-Physician consultation
- Patient education
- Data transmission
- Data interpretation
- 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)

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

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

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

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

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

Covered Services:

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

Scheduled Telephone Visits

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $20 per visit. Deductible does not apply.	50% of the Charges incurred.

Virtuwell visits through virtuwell.com

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

E-visits

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to a Copayment of $20 per visit. Deductible does not apply.	50% of the Charges incurred.

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.

TRANSPLANT SERVICES

Definitions:

Allogeneic. This is when the source of cells is from a related or unrelated donor's marrow or stem cells.

Allogeneic Bone Marrow Transplant. This is when the bone marrow is harvested from the related or unrelated donor and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is reinfused (transplanted).

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

Autologous/Allogeneic Stem Cell Support. This is a treatment process that includes stem cell harvest from either bone marrow or peripheral blood, tumor ablation with high-dose chemotherapy and/or radiation, stem cell reinfusion, and related care. Autologous/allogeneic bone marrow transplantation and high dose chemotherapy with peripheral stem cell rescue/support are considered to be autologous/allogeneic stem cell support.

Autologous Bone Marrow Transplant. This is when the bone marrow is harvested from the individual and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is reinfused (transplanted).

Designated Transplant Center. This is any Health Care Provider, group or association of Health Care Providers designated by us to provide services, supplies or drugs for specified transplants for our Insureds.

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

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

Covered Services:

Transplant Services must be received at a Designated Transplant Center.

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

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

The transplant-related treatment provided, including expenses incurred for directly related donor services, shall be subject to and in accordance with the provisions, limitations, maximums and other terms of this Benefits Chart. Unless the donor is a family member covered under the same Policy, donors are not considered Insureds and are therefore not eligible for the rights afforded to Insureds under this Policy. Ongoing medical care and/or treatment of medical complications that may occur to the donor are not covered. When the donor is a family member covered under the same Policy, medical and Hospital expenses of the donor are covered.

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

Network Benefits	**Out-of-Network Benefits**
60% of the Charges incurred.	No coverage.

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

Network Benefits	**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:

- Transplant Services provided by a Facility that is not a Designated Transplant Center. This does not apply to coverage required by the No Surprises Act as described in this Benefits Chart.
- 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

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 Policy. Additional coverage information is available in our Coverage Criteria Policies and Formulary. Log on to your "*my*HealthPartners" account or call Member Services to determine if additional requirements apply.

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

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

Certifications/Examinations

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

- To get or keep a job, including vocational assessments
- Required under a labor agreement or other contracts
- 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.
- For purposes of insurance
- To get or keep a license

Dental services

- Dental treatment, procedures or services not described under the "Dental Services" section
- 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
  - Accident-related dental services by an Out-of-Network Provider
- Oral surgery to remove wisdom teeth
- Orthognathic treatment or procedures and all related services, unless required to treat TMD or CMD and it meets our medical Coverage Criteria Policies

Investigative services

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

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

Nutrition

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

Physical appearance

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

Providers/Network

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

*These items do not apply to coverage required by the No Surprises Act as described in this Benefits Chart.

Reproductive and maternity care

- Infertility/fertility treatment and procedures, including, but not limited to, office visits, laboratory services, diagnostic imaging services and fertility drugs. This does not apply to office visits and consultations to diagnose infertility as described in the "Infertility Diagnosis" section.
- Reversal of sterilization
- Sperm, ova or embryo acquisition, retrieval or storage
- Surrogacy/gestational carrier compensation, services and fees
- Maternity services for a surrogate/gestational carrier not covered under this Policy
- Elective home births
- Elective abortions, except in the case of rape or incest, or in situations where the life of the mother would be endangered if the fetus is carried to full term

Services that are not Medically Necessary

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

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

Types of care

- Services provided by naturopathic providers
- Music therapy
- Massage therapy as a standalone treatment
- Routine foot care, unless you have one of the conditions (for example, diabetes) listed in our Coverage Criteria Policy. Call Member Services or log on to your "*my*HealthPartners" account at healthpartners.com for more information.
- Rest and respite services, including all services and medical equipment provided for such care, except as described under the "Home Hospice Services" section
- Custodial Care or Maintenance Care, including all services and medical equipment provided for such care
- Services provided by family members or residents in your home

- Halfway houses, group homes, extended care facilities, shelter services, transitional services, housing support programs and any comparable facilities, services or programs
- Correctional services and detention services
- Wilderness and outdoor programs even when the program is through a licensed Facility
- Animal therapy, including hippotherapy and equine therapy
- Foster care, adult foster care and any type of family childcare provided or arranged by the local state or county
- Court-ordered services or treatment, except as described in the "Behavioral Health Services" section
- Private duty nursing
- Acupuncture

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" or "Pediatric Eyewear" sections

Weight loss services

- All weight loss/bariatric surgery
- 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
- Biofeedback for weight loss
- Inpatient or day treatment programs for weight loss
- Weight loss drugs

All other exclusions

- All services, testing, equipment, devices, technologies and supplies purchased or available Over-the-Counter, including those recommended or managed by a Health Care Provider
- Health club memberships, exercise programs and use or purchase of exercise equipment
- Physical performance testing and measurement as part of an exercise program
- Lifestyle-behavioral resources or equipment, including, but not limited to, support groups and programs
- Services associated with non-covered services, including, but not limited to, treatment, procedures, diagnostic tests, monitoring, laboratory services, drugs and supplies. This exclusion does not apply to Medically Necessary complications related to an excluded service if they would otherwise be covered under this Policy.
- 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 Policy
- Services that would not otherwise be charged if you did not have health plan coverage
- Services you have no legal obligation to pay
- Charges from Providers who waive Copayment, Deductible and Coinsurance payments by the Insured, except in cases of undue hardship
- 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
- Services that are provided to you, if you also have other primary insurance coverage for those services and who does not provide us the necessary information to pursue Coordination of Benefits, as required under this Policy
- Travel, transportation, meals or lodging expenses
- 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.
- Services or items prohibited by law in the applicable jurisdiction in which they are received