HealthPartners Retiree National Choice Plan 2
Benefits Chart

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

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

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

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

The HealthPartners Retiree National Choice plan benefits constitute a Non-qualified plan.

Coverage may vary depending on whether you are receiving services from a primary care provider or from a specialty care provider.

Benefits are underwritten by HealthPartners Insurance Company. See the Group Certificate for additional information about limitations.

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

Charge: For covered services from providers/facilities that are Medicare certified and accept Medicare assignment, charge is (1) the Medicare allowable amount of the provider's billed charges for a given medical/surgical service, procedure or item or (2) the usual and customary charge if Medicare has not established a fee for a particular service.

For covered services from providers/facilities that are Medicare certified but do not accept Medicare assignment, charge is (1) the Medicare limiting amount of the provider's billed charges for a given medical/surgical service, procedure or item, or (2) the usual and customary charge if Medicare has not established a fee for a particular service.

The Usual and Customary Charge is the maximum amount allowed that we consider in the calculation of payment of charges incurred for certain covered services. Our payment is calculated using one of the following options to be determined at HealthPartners Insurance Company's discretion: 1) a percentage of the Medicare fee schedule; 2) a comparable schedule if the service is not on the Medicare fee schedule; or 3) a commercially reasonable rate for such service. You must pay for any charges above the usual and customary charge, and they do not apply to the out-of-pocket limit.

A charge is incurred for covered ambulatory medical and surgical services, on the date the service or item is provided. A charge is incurred for covered inpatient services, on the date of admission to a hospital. To be covered, a charge must be incurred on or after your effective date and on or before the termination date.

Copayment/Coinsurance: The specified dollar amount, or percentage, of charges incurred for covered services, which we do not pay, but which you must pay, each time you receive certain medical services, procedures or items. Our payment for those covered services or items begins after the copayment or coinsurance is satisfied. Covered services or items requiring a copayment or coinsurance are specified in this Benefits Chart.

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.

Out-of-Pocket Expenses: You pay the specified copayments/coinsurance 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 for covered services, to the individual out-of-pocket limit. Thereafter we cover 100% of charges incurred for all other covered services, for the rest of the calendar year. You pay amounts greater than the out-of-pocket limit if you exceed any visit or day limits.

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

The Supplemental Drug Benefit under this Certificate pays for a portion of your Part D drugs that are not covered under your HealthPartners Retiree National Choice (PDP) plan. Expenses incurred under the Supplemental Drug Benefit do not apply to the out-of-pocket limit under this Certificate.

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.

Individual Calendar Year Out-of-Pocket Limit

Benefits
$3,500

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

ACUPUNCTURE

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

Benefits
100% of the charges incurred, subject to your copayment of $15 per office visit.

Not Covered:

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

AMBULANCE AND MEDICAL TRANSPORTATION

Covered Services: We cover ambulance and medical transportation for medical emergencies. Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to an insured whose medical condition is such that other means of transportation could endanger the person's health or if authorized by us.

Non-emergency medical transportation by ambulance is appropriate if it is documented that the insured's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically necessary. **Ambulance services outside the United States are limited to ground ambulance to the nearest appropriate facility.**

Benefits
80% of the charges incurred.

Not Covered:

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

AUTISM BENEFIT

Covered Services:

We cover the diagnosis, evaluation, and multidisciplinary assessment and necessary care of children under 18 with autism spectrum disorders, including but not limited to the following:

(a) early intensive behavioral and developmental therapy based in behavioral and developmental science, including, but not limited to, all types of applied behavior analysis, intensive early intervention behavior therapy, and intensive behavior intervention;
(b) neurodevelopmental and behavioral health treatments and management;
(c) speech therapy;
(d) occupational therapy;
(e) physical therapy; and
(f) medications.

The diagnosis, evaluation and assessment includes an assessment of the child's developmental skills, functional behavior, needs and capacities. Treatment must be in accordance with an individualized treatment plan prescribed by the enrollee's treating physician or mental health professional.

We can request an updated treatment plan no more frequently than once every six months, unless we and your attending physician agree that a more frequent review is necessary due to emerging circumstances.

An independent progress evaluation conducted by a mental health professional with expertise and training in autism spectrum disorder and child development must be completed to determine if progress toward function and generalizable gains, as determined in the treatment plan, is being made.

Coverage for physical therapy, occupational therapy and speech therapy are covered under the "Physical Therapy, Occupational Therapy and Speech Therapy" section of this Benefits Chart. Coverage for medications is covered under the "Prescription Drug Services" section of this Benefits Chart.

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

Benefits
100% of the charges incurred, subject to your copayment of $10 per visit.

Not Covered:

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

BEHAVIORAL HEALTH SERVICES

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

Mental Health Services.

We cover services for mental health diagnoses as described in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM 5) (most recent edition).

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

Outpatient Services including intensive outpatient and day treatment services.

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

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

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

(1) Individual, group, family, and multi-family therapy;
(2) Medication management provided by a physician, certified nurse practitioner, or physician's assistant;
(3) Psychological testing services for the purposes of determining the differential diagnoses and treatment planning for patients currently receiving behavioral health services;
(4) Day treatment and intensive outpatient services in a licensed program;
(5) Partial hospitalization services in a licensed hospital or community mental health center;
(6) Psychotherapy and nursing services provided in the home if authorized by us; and
(7) Treatment for gender dysphoria that is medically necessary.

Benefits
100% of the charges incurred, subject to your copayment of $10 per visit.
For family therapy, only one copayment will be charged, regardless of the number of insureds primarily involved in the therapy.

Group Therapy.

Benefits
100% of the charges incurred, subject to your copayment of $5 per visit.

Inpatient Services, including psychiatric residential treatment.

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

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

Benefits
100% of the charges incurred, subject to your copayment of $400 per benefit period.

Chemical Health Services.

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

Outpatient Services, including intensive outpatient and day treatment services.

We cover medically necessary outpatient professional services for the diagnosis and treatment of chemical dependency. Chemical dependency treatment services must be provided by a program licensed by the local Department of Health and Human Services.

Outpatient services we cover for a diagnosed chemical dependency condition include the following:
(1) Individual, group, family, and multi-family therapy provided in an office setting;
(2) We cover opiate replacement therapy including methadone and buprenorphine treatment; and
(3) Day treatment and intensive outpatient services in a licensed program.

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

Benefits
100% of the charges incurred, subject to your copayment of $10 per visit. For family therapy, only one copayment will be charged, regardless of the number of insureds primarily involved in the therapy.

Inpatient Services.

We cover medically necessary inpatient services in a hospital or primary residential treatment in a licensed chemical health treatment center. Primary residential treatment is an intensive residential treatment program of limited duration, typically 30 days or less.

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

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

Benefits
100% of the charges incurred, subject to your copayment of $400 per benefit period.

Not Covered:

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

CHIROPRACTIC SERVICES

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

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

Benefits
100% of the charges incurred, subject to your copayment of $15 per office visit.

Not Covered:

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

CLINICAL TRIALS

Covered Services: We cover certain routine services if you participate in a Medicare-approved clinical trial. We cover routine patient costs for services that would be eligible under this Certificate as if the services were provided outside of a clinical trial.

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

Not Covered:

- A new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- 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.
- Items and services the study gives you or any participant for free.
- See "Services Not Covered" in the Group Certificate.

DENTAL SERVICES

Covered Services: We cover services as described below.

Medical Referral Dental Services.

a. 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.

Benefits
100% of the charges incurred.

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

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

In addition, we cover anesthesia and hospital charges for dental care incurred for an insured who is a child between age 5 and 12 and care in dental offices has been attempted unsuccessfully and usual methods of behavior modification have not been successful, or when extensive amounts of restorative care, exceeding four appointments, are required. The requirement of a hospital setting must be due to an insured's underlying medical condition. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist professional fees are not covered.

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

Benefits
100% of the charges incurred, subject to your copayment of $400 per benefit period.

c. 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.

Benefits
100% of the charges incurred.

Oral Surgery: We cover oral surgery. Coverage is limited to treatment of medical conditions requiring oral surgery, such as treatment of oral neoplasm, non-dental cysts, fracture of the jaws, trauma of the mouth and jaws, and any other oral surgery procedures provided as medically necessary dental services.

Benefits
100% of the charges incurred, subject to your copayment of $75 per office visit.

Treatment of Cleft Lip and Cleft Palate of a Dependent Child: We cover treatment of cleft lip and cleft palate of a dependent child to age 26, including orthodontic treatment and oral surgery directly related to the cleft. Benefits are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. Dental services which are not required for the treatment of cleft lip or cleft palate are not covered. If a dependent child covered under this Certificate is also covered under a dental plan which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same copayment, conditions and limitations as durable medical equipment.

Benefits
100% of the charges incurred.

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

Benefits
100% of the charges incurred.

Not Covered:

- Dental treatment, procedures or services not listed in this Benefits Chart.
- Oral surgery to remove wisdom teeth.
- Orthognathic treatment or procedures and all related services, unless it is required to treat TMD, CMD, cleft lip and cleft palate, and it meets our medical coverage criteria.
- See “Services Not Covered” in the Group Certificate.

DIAGNOSTIC IMAGING SERVICES

Covered Services: We cover diagnostic imaging, when ordered by a provider and provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services).

a. Outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT)

Benefits
90% of the charges incurred.

b. All other outpatient diagnostic imaging services

Benefits
90% of the charges incurred.

Not Covered:

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

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

Covered Services: We cover equipment, supplies and services, as described below.

Certain items are only covered if your condition meets our coverage criteria. In no event will coverage be limited to equipment only to be used in the home. For more information on what we cover and any prior authorization requirements, call Member Services or log on to your "*my*HealthPartners" account at healthpartners.com.

1. Durable medical equipment, such as wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices, hospital beds, and related services.
2. Prosthetics, including breast prostheses, artificial limbs and artificial eyes, and related supplies.
3. Orthotics.
4. Medical supplies, including splints, surgical stockings, casts and dressings.
5. Enteral feedings.
6. All physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes for insureds with gestational, Type I or Type II diabetes.
7. Special dietary treatment for Phenylketonuria (PKU) and oral amino acid based elemental formula if it meets our medical coverage criteria.
8. External hearing aids (including osseointegrated or bone anchored) for insureds age 18 or younger who have hearing loss that is not correctable by other covered procedures are covered. Coverage is limited to one hearing aid for each ear every three years.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies

Benefits
80% of the charges incurred.

Special dietary treatment for Phenylketonuria (PKU) if it meets our medical coverage criteria

Benefits
80% of the charges incurred.

Oral amino acid based elemental formula if it meets our medical coverage criteria

Benefits
80% of the charges incurred.

Limitations:

- Insulin-related supplies and equipment are limited to certain models and brands.
- Payment will not exceed the cost of an alternate piece of equipment or service that is effective and medically necessary.
- For prosthetic benefits, other than hair prostheses (i.e., wigs) for hair loss resulting from alopecia areata and oral appliances for cleft lip and cleft palate, payment will not exceed the cost of an alternate piece of equipment or service that is effective, medically necessary and enables insureds to conduct standard activities of daily living.
- We reserve the right to determine if an item will be approved for rental vs. purchase.
- Wigs for hair loss resulting from alopecia areata are limited to one per calendar year.
- No more than a 90-day supply of insulin-related supplies are covered and dispensed at a time.
- Durable medical equipment and supplies must be obtained from or repaired by approved vendors.
- Covered services and supplies are based on established medical policies which are subject to periodic review and modification by the medical or dental directors. Our coverage policy for insulin-related supplies includes information on our required models and brands. These medical policies (medical coverage criteria) are available by calling Member Services, or on our website at healthpartners.com.

Not Covered:

- Replacement or repair of any covered items, if the items are (i) damaged or destroyed by misuse, abuse or carelessness, (ii) lost; or (iii) stolen.
- Duplicate or similar items.
- Labor and related charges for repair of any covered items which are more than the cost of replacement by an approved vendor.
- Sales tax, mailing, delivery charges, service call charges.
- Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience or recreation.
- Communication aids or devices: equipment to create, replace or augment communication abilities including, but not limited to, speech processors, receivers, communication boards, or computer or electronic assisted communication, except as specifically described in this Certificate. This exclusion does not apply to cochlear implants, which are covered as described in the medical coverage criteria. Medical coverage criteria are available by calling Member Services, or logging on to your "*my*HealthPartners" account at healthpartners.com.
- Household equipment which primarily has customary uses other than medical, such as, but not limited to, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds.

- Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas.
- Modifications to the structure of the home including, but not limited to, its wiring, plumbing or charges for installation of equipment.
- Vehicle, car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier.
- Rental equipment while owned equipment is being repaired by non-contracted vendors, beyond one month rental of medically necessary equipment.
- Other equipment and supplies, including but not limited to assistive devices, that we determine are not eligible for coverage.
- See "Services Not Covered" in the Group Certificate.

EMERGENCY AND URGENTLY NEEDED CARE SERVICES

Covered Services: We cover services for emergency care and urgently needed care if the services are otherwise eligible for coverage under this Certificate. **Emergency care is available 24 hours a day, seven days a week.**

Urgently Needed Care. These are services to treat an unforeseen illness or injury, which are required in order to prevent a serious deterioration in your health, and which cannot be delayed until the next available clinic or office hours.

Urgently needed care at clinics

Benefits
Inside the United States: 100% of the charges incurred, subject to your copayment of $15 per office visit.
Outside the United States: 80% of the charges incurred.

Emergency Care. These are services to treat: (1) the sudden, unexpected onset of illness or injury which, if left untreated or unattended until the next available clinic or office hours, would result in hospitalization, or (2) a condition requiring professional health services immediately necessary to preserve life or stabilize health. Emergency care also includes an immediate response service available on a 24-hour, seven-day-a-week basis for each child, or person, having a psychiatric crisis, a mental health crisis, or a mental health emergency.

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

Emergency care in a hospital emergency room, including professional services of a physician

Benefits
Inside the United States: 100% of the charges incurred, subject to your copayment of $75 per visit. Emergency room copayment is waived if admitted for the same condition within 24 hours. **Outside the United States:** 80% of the charges incurred.

Inpatient emergency care in a hospital

Benefits
Inside the United States: 100% of the charges incurred, subject to your copayment of $400 per benefit period. **Outside the United States:** 80% of the charges incurred.

Not Covered:

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

EYEWEAR BENEFIT

Covered Services: We cover an eye exam and one pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)

Benefits
100% of the charges incurred for corrective eye glasses, contact lenses and their fitting.

Not Covered:

- Keratotomy and keratorefractive surgeries, eyeglasses, contact lenses and their fitting, except as specifically described in this Certificate.
- See "Services Not Covered" in the Group Certificate.

HEALTH EDUCATION

Covered Services: We cover education for preventive services and education for the management of chronic health problems, including diabetes. Coverage includes medical nutrition therapy that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association.

Benefits
100% of the charges incurred.

Not Covered:

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

HEARING AID BENEFIT

We cover hearing aids. Coverage includes the initial hearing aid fitting sessions if prescribed by a physician as medically necessary. Coverage does not include hearing aid batteries or repairs.

Hearing aids.

Benefits
100% of the charges incurred, subject to a maximum benefit of $1,000 every two years.

Initial hearing aid fitting sessions if prescribed by a physician as medically necessary care.

Benefits
100% of the charges incurred.

Not Covered:

- Hearing aids (implantable and external, including osseointegrated or bone anchored) and their fitting, except as specifically described in this Benefits Chart.
- See "Services Not Covered" in the Group Certificate.

HOME BASED PALLIATIVE CARE

We cover home-based palliative care coordination and counseling visits provided by a registered nurse or medical social worker if you have a life-threatening, non-curable condition which has a prognosis of survival of two years or less. We waive the Medicare requirement that you be homebound for a limited number of home visits for palliative care.

Benefits
100% 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 nurse or social worker visits per plan year. Additional palliative care visits in the home are eligible under the Medicare home health care benefit if you are homebound and meet all other Medicare requirements for home health care services.

Not Covered:

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

HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Covered Services: We cover services as described below.

Medical or Surgical Hospital Services

Inpatient Hospital Services: We cover the following medical or surgical services, for the treatment of acute illness or injury, which require the level of care only provided in an acute care facility. These services must be authorized by a physician.

Inpatient hospital services include: room and board; the use of operating or maternity delivery rooms; intensive care facilities; newborn nursery facilities; general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, prescription drugs or other medications administered during treatment, blood and blood products (unless replaced), and blood derivatives, and other diagnostic or treatment related hospital services; physician and other professional medical and surgical services provided while in the hospital, including gender reassignment surgery that is medically necessary.

Covered maternity services will be provided to all insureds eligible under this Certificate, regardless of marital status.

We cover up to 120 hours of services provided by a private duty nurse or personal care assistant who has provided home care services to a ventilator-dependent patient, solely for the purpose of assuring adequate training of the hospital staff to communicate with that patient.

We cover, following a vaginal delivery, a minimum of 48 hours of inpatient care for the mother and newborn child. We cover, following a caesarean section delivery, a minimum of 96 hours of inpatient care for the mother and newborn child. If the duration of inpatient care is less than these minimums, we also cover a minimum of one home visit by a registered nurse for post-delivery care, within 4 days of discharge of the mother and newborn child. Services provided by the registered nurse include, but are not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. We shall not provide any compensation or other non-medical remuneration to encourage a mother and newborn to leave inpatient care before the duration minimums specified.

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

Benefits
100% of the charges incurred, subject to your copayment of $400 per benefit period.

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

Outpatient services include: use of operating rooms, maternity delivery rooms or other outpatient departments, rooms or facilities; and the following outpatient services: general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, drugs administered during treatment, blood and blood products (unless replaced), and blood derivatives, and other diagnostic or treatment related outpatient services; physician and other professional medical and surgical services provided while an outpatient, including gender reassignment surgery that is medically necessary.

Covered maternity services will be provided to all insureds eligible under this Certificate, regardless of marital status.

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

Outpatient non-surgical Services

Benefits
100% of the charges incurred.

Outpatient surgeries

Benefits
100% of the charges incurred, subject to your copayment of $200 per visit.

Skilled Nursing Facility Care: We cover room and board, daily skilled nursing and related ancillary services for post acute treatment and rehabilitative care of illness or injury, following a hospital confinement of three or more days.

Benefits
100% of the charges incurred for days 1-20; $125 per day for days 21-100.

Limitations:

- Skilled nursing facility care is limited to a 100 day maximum per benefit period.

Not Covered:

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

LABORATORY SERVICES

Covered Services: We cover laboratory tests when ordered by a provider and provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services).

Services for illness or Injury

Benefits
100% of the charges incurred.

Preventive services

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

Not Covered:

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

LYME DISEASE SERVICES

Covered Services: We cover services for the treatment of Lyme disease.

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

Not Covered:

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

MASTECTOMY RECONSTRUCTION BENEFIT

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

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

Not Covered:

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

OFFICE VISITS FOR ILLNESS OR INJURY

Covered Services: We cover the following when medically necessary: professional medical and surgical services and related supplies, including biofeedback, of physicians and other health care providers; blood and blood products (unless replaced) and blood derivatives.

We cover diagnosis and treatment of illness or injury to the eyes.

We also provide coverage for the initial physical evaluation of a child if it is ordered by a Minnesota juvenile court.

Office Visits

Benefits
Primary Care Providers: 100% of the charges incurred, subject to your copayment of $10 per office visit. Specialty Care Providers: 100% of the charges incurred, subject to your copayment of $15 per office visit.

E-visits: We cover an online exchange of non-urgent medical information between a health care provider and an established patient, where the provider gives the patient medical advice. An E-visit is conducted over a secure encrypted website, and is an alternative to an office visit.

Benefits
100% of the charges incurred.

Scheduled Telephone Visits: We cover telephone assessments or evaluation and management visits between a health care provider and an established patient conducted over the phone, as an alternative to an office visit.

Benefits
100% of the charges incurred.

Real-time Interactive Audio and Video Technologies: We cover secure, online real-time video consultations between a patient and a provider to diagnose and treat some conditions.

Benefits
Primary Care Providers: 100% of the charges incurred, subject to your copayment of $10 per visit. Specialty Care Providers: 100% of the charges incurred, subject to your copayment of $15 per visit.

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

Benefits
100% of the charges incurred.

Injectable and implantable birth control drugs/devices (this provision applies whether the birth control drug/device is used for birth control or for a medically necessary purpose other than birth control)

Benefits
80% of the charges incurred.

Not Covered:

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

PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY

Covered Services: We cover the following physical therapy, occupational therapy and speech therapy services when they are provided in a clinic or an outpatient hospital facility:

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

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

We cover services provided in a clinic. We also cover therapies provided in an outpatient hospital facility. To see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services.

Physical Therapy and Occupational Therapy

Rehabilitative Care

Benefits
100% of the charges incurred, subject to your copayment of $15 per office visit.

Speech Therapy

Rehabilitative Care

Benefits
100% of the charges incurred, subject to your copayment of $15 per office visit.

Not Covered:

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

PORT WINE STAIN REMOVAL SERVICES

Covered Services: We cover port wine stain removal services.

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

Not Covered:

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

PRESCRIPTION DRUG SERVICES

Covered Services: We cover drugs covered under Part B of the Original Medicare Plan. We cover off-label use of drugs covered under Part B of the Original Medicare Plan to treat cancer if the drug is recognized for the treatment of cancer in any authoritative compendia used by the Medicare program. We also cover orally administered anticancer drugs covered under Part B of the Original Medicare plan. We are in compliance with Minnesota Statute 62A.3075 because we cover orally administered anticancer drugs at the same benefit level as all other drugs covered under Part B of the Original Medicare plan.

For drugs covered under Medicare Part D Prescription Drug Coverage, see your HealthPartners Retiree National Choice (PDP) Evidence of Coverage.

Drugs Covered Under Part B of Medicare

Benefits
80% of the charges incurred.

Not Covered:

- Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
- Prescription drugs covered under Medicare Part D Prescription Drug coverage.
- See "Services Not Covered" in the Group Certificate.

PREVENTIVE SERVICES

Covered Services: We cover the following eligible preventive services.

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

1. **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.

Benefits
100% of the charges incurred.

2. **Child health supervision services,** including pediatric preventive services, routine immunizations, developmental assessments and laboratory services appropriate to the age of the child from birth to 72 months, and appropriate immunizations to age 18.

Benefits
100% of the charges incurred.

3. **Routine prenatal care and exams,** to include visit-specific screening tests, education and counseling.

Benefits
100% of the charges incurred.

4. **Routine postnatal care and exams,** to include health exams, assessments, education and counseling relating to the period immediately after childbirth.

Benefits
100% of the charges incurred.

5. **Routine screening procedures for cancer**, including:

- Breast cancer screening (mammograms). Covered services include:
  - One baseline mammogram between the ages of 35 and 39.
  - One screening mammogram every 12 months for women age 40 and older.
  - Clinical breast exams once every 24 months.
- Cervical and vaginal cancer screening. Covered services include:
  - For all women: Pap tests and pelvic exams are covered once every 24 months.
  - If an insured is at high risk of cervical or vaginal cancer or is of childbearing age and has had an abnormal Pap test within the past 3 years: one Pap test every 12 months.
- Colorectal cancer screening.
  - For insureds 50 and older, the following are covered:
    - Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months.
  - One of the following every 12 months:
    - Guaiac-based fecal occult blood test (gFOBT).
    - Fecal immunochemical test (FIT).
  - DNA based colorectal screening every 3 years.
  - For people at high risk of colorectal cancer, the following is covered:
    - Screening colonoscopy (or screening barium enema as an alternative) every 24 months.
  - For people not at high risk of colorectal cancer, the following is covered:
    - Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy.
- Prostate cancer screening exams. For men 40 years of age or over who are symptomatic or in a high-risk category and for all men age 50 and older, covered services include the following, once every 12 months:
  - Digital rectal exam.
  - Prostate Specific Antigen (PSA) test.
- Screening for lung cancer with low dose computed tomography (LDCT). For qualified individuals, a LDCT is covered every 12 months.

  Eligible insureds are people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.

For LDCT lung cancer screenings after the initial LDCT screening: the insured must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.

- Ovarian cancer screening including surveillance tests for women who are at risk as defined below.

"At risk for ovarian cancer" means:

(a) having a family history:
  (i) with one or more first- or second-degree relatives with ovarian cancer;
  (ii) of clusters of women relatives with breast cancer; or
  (iii)of nonpolyposis colorectal cancer; or
(b) testing positive for BRCA1 or BRCA2 mutations.

"Surveillance tests for ovarian cancer" means annual screening using:

(i) CA-125 serum tumor marker testing;
(ii) transvaginal ultrasound;
(iii)pelvic examination; or
(iv)other proven ovarian cancer screening tests currently being evaluated by the federal Food and Drug Administration or by the National Cancer Institute.

Benefits
100% of the charges incurred.

6. Routine eye and hearing exams

Benefits
100% of the charges incurred.

7. Adult immunizations

Benefits
100% of the charges incurred.

8. Obesity screening and management. If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your doctor or practitioner to find out more.

Benefits
100% of the charges incurred.

9. **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use).** If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits. We offer, as a supplemental benefit, additional sessions of face-to-face counseling and interactive on-line and telephone-based coaching.

Benefits
100% of the charges incurred.

Not Covered:

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

SILVER&FIT® BENEFIT

Covered Services: The following two Silver&Fit program options are offered:

1. **The Silver&Fit Fitness Center Program** offers membership at a fitness center or YMCA participating in an extensive network. Membership includes standard fitness facility services. Nonstandard services that typically require an additional fee are not included. There are no monthly membership dues and no fee to switch fitness facilities.

Benefits
100% of the charges incurred.

2. **The Silver&Fit Home Fitness Program** may be selected by members who prefer to work out at home or who are unable to go to a fitness center or YMCA.

Benefits
100% of the charges incurred.

For questions or to enroll in the Silver&Fit program, visit **Silverandfit.com** or call Silver&Fit customer service at 888-797-8902 (TTY 711) Monday through Friday, 7:00 a.m. to 8:00 p.m. CT.

The Silver&Fit program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). All programs and services are not available in all areas. Silver&Fit is a federally registered trademark of ASH and used with permission herein. Not all YMCAs participate in the network. Please check the searchable directory on the Silver&Fit website to see if your location participates in the program.

Limitations:

- The Silver&Fit Home Fitness Program kits are limited to two per year.

Not Covered:

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

SUPPLEMENTAL DRUG BENEFIT

Covered Services: Your employer has purchased coverage above your Part D defined standard benefit. Your Part D drug benefit has been calculated as described in Chapter 4 of your HealthPartners Retiree National Choice (PDP) plan. This benefit is subject to Part D prescription drug requirements.

You may be granted an exception to the formulary for anti-psychotic prescription drugs prescribed to treat emotional disturbances or mental illness if your health care provider (1) indicates to the dispensing pharmacist, orally or in writing, that the prescription must be dispensed as indicated and (2) certifies in writing to us that the prescribed drug will best treat your condition. Also, you may continue to receive certain non-formulary prescription drugs for diagnosed mental illness or emotional disturbance when our formulary changes or you change health plans for up to one year following the change.

TPN/IV THERAPY, AND IVIG FOR THE TREATMENT IN THE HOME OF PRIMARY IMMUNE DEFICIENCY DISEASES

Covered Services: We cover Medicare-covered total parenteral nutrition/intravenous (TPN/IV) therapy, Intravenous Immune Globulin (IVIG) for the treatment of primary immune deficiency diseases, equipment, supplies and drugs in connection with IV therapy. IV line care kits are covered under "Durable Medical Equipment."

Benefits
100% of the Medicare Part B coinsurance for Medicare-covered services.

Not Covered:

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

TRANSPLANT SERVICES

Covered Services: Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If local transplant providers are willing to accept the Original Medicare rate, then you can choose to obtain your transplant services locally or at a distant location offered under this Certificate. If we provide transplant services at a distant location and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.

Benefits
See Inpatient Hospital Services Benefit.

Limitations:

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

Not Covered:

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

WEIGHT LOSS SURGERY OR BARIATRIC SURGERY

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

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

Not Covered:

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

WORLDWIDE EMERGENCY TRAVEL LOGISTICS

Covered Services: If you think you need medical care while you are at least 100 miles from your permanent residence or in a foreign country, you may call Assist America 24 hours a day, 7 days a week at 1-800-872-1414 (inside the United States) or 1-609-986-1234 (outside the United States). Experienced clinicians will assist you in assessing your need for medical care and coordinate post-stabilization transport to the nearest medical facility or home.

Benefits
100% of the charges incurred.

Limitations:

- All arrangements must be made through Assist America. Please provide reference number 02-AA-HPT-05133M when you call.
- This service is only available during the first 90 consecutive days that you are away from your permanent residence.