HealthPartners UnityPoint Health
Gold Iowa Small Employer Plan
Benefits Chart

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

UNDERSTANDING YOUR COVERAGE

This Benefits Chart is the part of the Group Certificate (Certificate) 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 Certificate, our Medical Policies and your drug Formulary.

Our Medical Policies (Coverage Criteria Policies) list specific criteria that must be met for certain supplies, Health Care Services, behavioral health services and procedures to be considered Medically Necessary or Dentally 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 account at HealthPartnersUnityPointHealth.com or call Member Services.

Benefits are underwritten by HealthPartners UnityPoint Health, Inc.

HOW TO USE THIS BENEFITS CHART

This Benefits Chart is divided into sections based on different types of care or services. Each section includes the amount or percentage we pay for Covered Services when received from Network and Out-of-Network Providers. When needed, sections will also include specific limitations or conditions for that coverage. You are responsible for the specified Copayment amount and/or percentage of Charges that we do not pay. You are also responsible for all Charges related to any non-covered services. Please refer to any "Not Covered" lists in each benefit category as well as the "Services Not Covered" section to better understand your coverage.

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

HOW YOUR CHOICE OF PROVIDERS AFFECTS YOUR COVERAGE

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.

Under the No Surprises Act, Health Care Providers and Facilities are required to provide patients with a plain-language consumer notice explaining that patient consent is required to receive non-emergency care on an Out-Of-Network basis before that Provider can bill at the higher Out-Of-Network rate.

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

GENERAL DEFINITIONS

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

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.

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 or Dentally Necessary and covered by us, as described in this Benefits Chart.

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

Deductible. The specified dollar amount of Charges incurred for Covered Services, which we do not pay, but an Insured or a family has to pay first in a Calendar Year. Our payment for those services or items begins after the deductible is satisfied. For Network Providers, the amount of the Charges that apply to the deductible are based on the Network Provider’s discounted Charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule rate for case rate or withhold arrangements. For Out-of-Network Providers, the amount of Charges that apply to the deductible are the lesser of the Provider’s Charges or the usual and customary charge for a service.

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

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

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

Dentally Necessary Care. This is care which is limited to diagnostic testing, treatment, and the use of dental equipment and appliances which, in the judgment of a dentist, is required to prevent deterioration of dental health, or to restore dental function. Your general health condition must permit the necessary procedure(s). Decisions about dental necessity are made by our dental director or their designee.

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

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

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

- There is final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the United States Food and Drug Administration (FDA)
- 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. Each article must use generally acceptable scientific standards and must not use case reports to satisfy this criterion.

Lifetime Maximum Benefit. The specified coverage limit actually paid by us for services and/or Charges incurred by you for a given procedure or diagnosis. Payment of benefits under this Benefits Chart ceases when that lifetime maximum benefit is reached. You have to pay for any subsequent Charges. Essential health benefits are not subject to any lifetime maximums.

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 diagnostic testing and medical treatment and Prescription Drug use which is medically appropriate to your physical or mental diagnosis for an Injury or Illness, and Preventive Services covered in the Certificate. medically necessary care must meet the following criteria:

- it meets clinically accepted medical services and practice parameters of the general medical community; and
- it meets 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 or supplies cannot be safely provided in a lower level of care setting; and
- it restores or maintains health; or

- it prevents deterioration of your condition; or
- it prevents the reasonably likely onset of a health problem or detects an incipient problem.

To be considered medically necessary care, it must not be Maintenance or Custodial Care, or ineffective care, or otherwise excluded in the Certificate. The fact that an authorized Network, or Out-of-Network, Provider prescribes treatment does not necessarily mean the treatment is covered under the Certificate.

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

Out-of-Pocket Limit. You pay the Copayments/Coinsurance and Deductibles for Covered Services, to the individual or family out-of-pocket limit. Thereafter we cover 100% of 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. Essential health benefits are not subject to any Lifetime Maximums.

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

Out-of-Network Benefits for transplant surgery and bariatric surgery do not apply to the out-of-pocket limit.

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

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

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

Primary Care Providers. These are Providers in the following categories: family practice, general practice, internal medicine, obstetrical and gynecological 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, obstetrical and gynecological medicine, pediatrics, adolescent medicine, adult medicine and geriatrics.

DEDUCTIBLES AND OUT-OF-POCKET LIMITS

Individual Calendar Year Deductible

Network Benefits	Out-of-Network Benefits
$4,000	$10,000

Family Calendar Year Deductible

Network Benefits	Out-of-Network Benefits
$8,000	$20,000

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

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

Any amounts paid or reimbursed by a third party, including but not limited to, point of service rebates, manufacturer coupons, manufacturer 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
$7,000	$30,000

Family Calendar Year Out-of-Pocket Limit

Network Benefits	Out-of-Network Benefits
$14,000	$60,000

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

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

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

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

YOUR BENEFITS

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

AMBULANCE AND MEDICAL TRANSPORTATION

Covered Services:

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

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

Non-emergency fixed wing air ambulance requires prior authorization.

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

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

Network Benefits	Out-of-Network Benefits
70% 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.

BEHAVIORAL HEALTH SERVICES

Definitions:

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

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

Covered Services:

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 account at HealthPartnersUnityPointHealth.com or call Member Services to determine if additional Coverage Criteria Policies apply.

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

A comprehensive diagnostic assessment will be used as the basis for a determination by a Mental Health Professional, concerning the appropriate treatment and the extent of services required.

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

- Individual, group, family, and multi-family therapy
- Medication management provided by a Physician, certified nurse practitioner, or Physician assistant
- Psychological testing services for the purposes of determining the differential diagnoses and treatment planning for patients currently receiving behavioral health services
- Day treatment and intensive Outpatient services in a licensed program
- Partial hospitalization services in a licensed Hospital or community mental health center
- Psychotherapy and nursing services provided in the home
- Treatment for gender dysphoria.

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

Network Benefits	**Out-of-Network Benefits**
100% of the Charges incurred, subject to your Copayment of $30 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 your Copayment of $15 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 services. This care must be authorized by us and provided by a Hospital or Residential Behavioral Health Treatment Facility licensed by the local state or Department of Health and Human Services. Services not covered under this benefit include halfway houses, group homes, extended care Facilities, shelter services, correctional services, detention services, transitional services, housing support programs, foster care services and wilderness and outdoor programs.

Network Benefits	**Out-of-Network Benefits**
70% of the Charges incurred.	50% of the Charges incurred.

Substance use disorder (SUD) services

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

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

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

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

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $30 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.

Inpatient services. We cover the following:

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

Network Benefits	Out-of-Network Benefits
70% of the Charges incurred.	50% of the Charges incurred.

Not Covered:

- Court-ordered mental health treatment
- 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 as part of a prescribed treatment plan and is not billed separately.

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

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $30 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 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. We cover routine patient costs for services that would be eligible under this Benefits Chart if the service were provided outside of a clinical trial.

Log on to your account at HealthPartnersUnityPointHealth.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 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 the services described below. Log on to your account at HealthPartnersUnityPointHealth.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 timeframe and must be directly related to the accident. We do not cover restoration and replacement of teeth that are not "sound and natural" at the time of the accident.

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

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

Network Benefits	Out-of-Network Benefits
70% of the Charges incurred.	50% of the Charges incurred.

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

Medical referral dental services

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

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $60 per visit. Deductible does not apply.	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 risk if not completed in a Hospital or ambulatory surgery center
- Extensive procedures which prevent an oral surgeon from providing general anesthesia in the office, regardless of age

Anesthesia is covered in a Hospital or 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
70% 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
100% of the Charges incurred, subject to your Copayment of $60 per visit. Deductible does not apply.	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 jaws, trauma of the mouth and jaws and any other oral surgery procedures provided as Medically Necessary dental services.

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

Treatment of cleft lip and cleft palate of a Dependent Child. We cover treatment of cleft lip and cleft palate of a Dependent Child age 25 or younger, including orthodontic treatment and oral surgery directly related to the cleft. Benefits are limited to Inpatient or Outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. Dental services which are not required for the treatment of cleft lip or cleft palate are not covered. If a Dependent Child covered under the Certificate is also covered under a dental plan which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same Coinsurance, conditions and limitations as durable medical equipment.

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

Treatment of temporomandibular disorder (TMD) and craniomandibular disorder (CMD). We cover diagnostic procedures, surgical treatment and non-surgical treatment for TMD and CMD. Services must be Medically Necessary and administered or prescribed by a Physician or dentist. Dental services which are not required to directly treat TMD or CMD are not covered.

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

Not Covered:

- Dental treatment, procedures or services not described above or in the "Dental Services - Pediatric Dental" 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
- Oral surgery to remove wisdom teeth, except as stated in the "Dental Services - Pediatric Dental" section
- Orthognathic treatment or procedures and all related services

DENTAL SERVICES – PEDIATRIC DENTAL

This section applies to individuals age 18 or younger and continues until the end of the month in which the individual turns age 19.

Definitions:

Clinically Accepted Dental Services. These are techniques or services, accepted for general use, based on risk/benefit implications (evidence based). Some Clinically Accepted techniques are approved only for limited use, under specific circumstances.

Consultations. These are diagnostic services provided by a Dentist or dental specialist other than the practitioner who is providing treatment.

Cosmetic Care. These are dental services to improve appearance, without treatment of a related Illness or Injury.

Customary Restorative Materials. These are amalgam (silver fillings), glass ionomer and intraorally cured acrylic resin and resin-based composite materials (white fillings).

Date of Service. This is generally the date the dental service is performed. For prosthetic, or other special restorative procedures, the Date of Service is the date impressions were made for final working models. For endodontic procedures, Date of Service is the date on which the root canal was first entered for the purpose of canal preparation.

Dentist. This is a professionally degreed doctor of dental surgery or dental medicine who lawfully performs a dental service in strict accordance with governmental licensing privileges and limitations.

Elective Procedures. These are procedures which are available to patients but which are not Dentally Necessary.

Emergency Dental Care. These are services for an acute dental condition that would lead a prudent layperson to reasonably expect that the absence of immediate care would result in serious impairment to the dentition or would place the person's oral health in serious jeopardy.

Endodontics. This is the treatment of diseases of the dental pulp. Endodontics includes root canal therapy, pulp capping procedures, apexification and periapical procedures associated with root canal treatment.

Medically Necessary Orthodontic Services. These are comprehensive Medically Necessary services covered for pediatric dental Insureds who have a severe handicapping malocclusion related to a medical condition resulting from congenital, craniofacial or dentofacial malformations involving the teeth and requiring Reconstructive Surgical correction in addition to Orthodontic services.

Oral Surgery. This is routine surgery involving teeth or alveolar bone, including extraction and alveolectomy. Oral surgery may include other oral treatment and surgery, if a Dentist considers it Dentally Necessary. Oral surgery does not include orthodontia, Orthognathic Surgery, and placement of dental implants or surgical care that is necessary because of a medical condition.

Orthodontics. This is Medically Necessary dental care for the correction of severe handicapping malocclusion of teeth using appliances and techniques that alter the position of teeth in the jaws.

Orthognathic Surgery. This is Oral Surgery to alter the position of the jaw bones.

Periodontics. This is non-surgical and surgical treatment of diseases of the gingiva (gums) and bone supporting the teeth.

Prosthetic Services. These are services to replace missing teeth; including the prescribing, repair, construction, replacement and fitting of fixed bridges and full or partial removable dentures.

Covered Services:

We cover Preventive and Diagnostic Services, Basic, Special, Prosthetic and Medically Necessary Orthodontia Services only, for Insureds age 18 or younger. To be covered, dental services or items described below must be Medically Necessary or Dentally Necessary. The Date of Service must be while you are enrolled in the plan.

Emergency Dental Care provided by Network Providers or Out-of-Network Providers is covered to the same extent as eligible dental services described in this section and subject to the same Deductibles, Coinsurance and maximums.

Preventive and Diagnostic Services

We cover the following preventive and Diagnostic Services for Insureds age 18 or younger, with certain limitations which are listed below.

- Routine dental care examinations for new and existing patients – limited to twice each Calendar Year
- Dental cleaning (prophylaxis or periodontal maintenance cleaning) – limited to twice each Calendar Year
- Professionally applied topical fluoride (other than silver diamine fluoride) – limited to twice each Calendar Year
- Silver diamine fluoride – limited to twice per tooth each Calendar Year
- Pit and fissure sealant application and preventive resin restoration – limited to one application per tooth per 36-month period, for unrestored permanent molars
- Bitewing x-rays – limited to twice each Calendar Year
- Full mouth or panoramic x-rays – limited to once every 60 months
- Other x-rays, except as provided in connection with Orthodontic Diagnostic procedures and treatment
- Space maintainers (fixed or removable appliances designed to prevent adjacent and opposing teeth from moving) – for lost primary teeth

- Evaluations that are not routine and periodic, including: problem-focused evaluations (either limited or detailed and extensive), periodontal evaluations, and evaluations for Insureds age 2 or younger which include counseling with the primary caregiver
- Screening or assessments of a patient – limited to twice each Calendar Year

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

Basic Services

We cover the following services for Insureds age 18 or younger:

- Consultations
- Emergency treatment for relief of pain
- Silver fillings on any tooth and tooth-colored fillings on anterior teeth. Restorations using Customary Restorative Materials and stainless steel crowns are covered, when Dentally Necessary due to loss of tooth structure as a result of tooth decay or fracture.
- White (tooth-colored) fillings on bicuspids and molars). Restorations using Customary Restorative Materials and preventive resin restorations are covered, when Dentally Necessary due to loss of tooth structure as a result of tooth decay or fracture
- Oral Surgery – Surgical and non-surgical extraction for the restoration of dental function. Services include, but are not limited to, removal of impacted teeth, incision or drainage of abscesses and removal of exostosis. General anesthesia or intravenous sedation is covered, when Dentally Necessary, when provided by the attending Dentist in a dental office setting and required to perform a covered dental procedure.
- Periodontics (gum disease) – limited to once every 24 months for non-surgical treatment and once every 36 months for surgical treatment
- Endodontics

Network Benefits	Out-of-Network Benefits
70% of the Charges incurred.	50% of the Charges incurred.

Collection and application of autologous blood concentrate product is limited to once every 36 months.

Special Services

We cover the following services for Insureds age 18 or younger:

- Special Restorative Care. Extraorally fabricated or cast restorations (crowns, onlays) are covered when teeth cannot be restored with Customary Restorative Material and when Dentally Necessary due to the loss of tooth structure as a result of tooth decay or fracture. If a tooth can be restored with a Customary Restorative Material, but an onlay, crown, jacket, indirect composite or porcelain/ceramic restoration is selected, benefits will be calculated using the Charge appropriate to the equivalent Customary Restorative Material.
- Repair or recementing of crowns, inlays and onlays

Network Benefits	Out-of-Network Benefits
70% of the Charges incurred.	50% of the Charges incurred.

Benefits for the replacement of a crown or onlay will be provided only after a five year period measured from the date on which the procedure was last provided, whether under this Benefits Chart or not.

A crown or onlay must be installed within 60 days after termination of coverage.

Prosthetic Services

We cover the following services for Insureds age 18 or younger:

- Bridges. Initial installation of fixed bridgework to replace missing natural teeth, replacement of an existing fixed bridgework by a new bridgework, the addition of teeth to an existing bridgework, and repair or recementing of bridgework are covered. A given prosthetic appliance for the purpose of replacing an existing appliance will be provided when satisfactory evidence is presented that the new prosthetic appliance is required to replace one or more teeth extracted after the existing bridgework was installed.
- Dentures. Initial installation of full removable dentures to replace missing natural teeth and adjacent structures and adjustments during the six-month period following installation are covered. If a satisfactory result can be achieved through the utilization of standard procedures and materials but a personalized appliance is selected, or one which involves specialized techniques, the Charges appropriate to the least costly appliance are covered. Replacement of an existing full removable denture by a new denture is covered. A given prosthetic appliance for the purpose of replacing an existing appliance will be provided when satisfactory evidence is presented that the new prosthetic appliance is required to replace one or more teeth extracted after the existing denture was installed. Repair of dentures, or relining or rebasing of dentures more than six months after installation of an initial or replacement denture are covered.
- Partial Dentures. Surveyed crowns which are not restorative but which are Dentally Necessary to facilitate the placement of a removable partial denture are covered. Initial installation of partial removable dentures to replace missing natural teeth and adjacent structures and adjustments during the six-month period following installation are covered. If a satisfactory result can be achieved by a standard cast chrome or acrylic partial denture, but a more complicated design is selected, the Charges appropriate to the least costly appliance are covered. Replacement of an existing partial denture by a new denture, or the addition of teeth to an existing partial removable denture is covered. A given prosthetic appliance for the purpose of replacing an existing appliance will be provided when satisfactory evidence is presented that the new prosthetic appliance is required to replace one or more teeth extracted after the existing denture was installed. Repair of dentures, or relining or rebasing of dentures more than six months after installation of an initial or replacement denture are covered.
- Occlusal guards. Occlusal guards for the treatment of bruxism are covered, including repair and relining of occlusal guards. Occlusal guards are limited to one every 12 months, for Insureds age 13 or older
- Tissue Conditioning

Network Benefits	**Out-of-Network Benefits**
70% of the Charges incurred.	50% of the Charges incurred.

Benefits for replacement of a prosthetic appliance will be provided only (a) if the existing appliance cannot be made serviceable, and (b) after a five year period measured from the date on which it was installed, whether under this Benefits Chart or not.

A prosthetic appliance must be installed or delivered within 60 days after termination of coverage.

Dental Implant Services

We cover the following services for Insureds age 18 or younger, if Dentally Necessary:

- The surgical placement of an implant body to replace missing natural permanent teeth other than congenitally missing teeth
- Removal and replacement of an implant body that is not serviceable and cannot be repaired after a period of at least five years from the date that the implant body was initially placed
- Initial installation of implant-supported prosthesis (crowns, bridgework and dentures) to replace missing teeth
- Replacement of an existing implant-supported prosthesis by a new implant-supported prosthesis, or the addition of teeth to an existing implant-supported prosthesis. We will replace an existing implant-supported prosthesis when satisfactory evidence is presented that (a) the new implant-supported prosthesis is required to replace one or more teeth extracted after the existing implant-supported prosthesis was installed, or (b) the existing implant-supported prosthesis cannot be made serviceable
- Repair of implant-supported prosthesis

Decisions about Dental Necessity are made by HealthPartners UnityPoint Health, Inc.'s dental directors, or their designees. If the dental directors or their designees determine that a tooth or an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedure. For the second phase of treatment (the prosthodontics phase of placing the implant crown, bridge, denture or partial denture), we will base benefits on the least costly, professionally acceptable alternative treatment.

Network Benefits	Out-of-Network Benefits
70% of the Charges incurred.	50% of the Charges incurred.

Any benefits for replacement of an implant-related service or grafting related to implants will be provided only after a five year period measured from the date the service was provided, whether under this Benefits Chart or not.

Implants (including hardware), implant-supported complete or partial dentures, connecting bars, abutments, implant-supported crowns, and abutment supported retainers are limited to once every five years.

Radiographic/surgical implant indexing is limited to once every five years.

The surgical placement of a dental implant body and all associated dental implant-related services to replace missing primary natural teeth or congenitally missing permanent natural teeth are not covered.

Cleft Lip and Cleft Palate Dental Services

We cover dental services for treatment of cleft lip and cleft palate for Insureds age 18 or younger. Orthodontic treatment of cleft lip and cleft palate will be covered only if it meets the Covered Services criteria under the "Orthodontic Services" section.

Network Benefits	Out-of-Network Benefits
Coverage level is the same as corresponding Network Benefits, depending on the type of service provided, such as Basic Services or Special Services, if applicable.	Coverage level is the same as corresponding Out-of-Network Benefits, depending on the type of service provided, such as Basic Services or Special Services, if applicable.

Orthodontic Services

We cover Medically Necessary Orthodontic Services necessary for the correction of severe handicapping malocclusion of teeth for Insureds age 18 or younger. Orthodontia may be considered Medically Necessary when the treatment is intended to correct a medical condition resulting from congenital, craniofacial or dentofacial malformations involving the teeth and requiring Reconstructive Surgical correction in addition to Orthodontic Services. Each Orthodontic treatment includes:

- Treatment necessary for the correction of severe handicapping malocclusion of teeth
- Initial post-treatment retainers

Benefits will be paid over the course of Orthodontic treatment.

Network Benefits	Out-of-Network Benefits
70% of the Charges incurred.	No Coverage.

Not Covered:

- Dental services, supplies and devices not expressly covered as a benefit under this section
- Dental services or supplies primarily intended to alter the shape, appearance and function of the teeth for Cosmetic purposes, or for the purpose of improving the appearance of your teeth. This includes tooth whitening, tooth bonding and veneers that cover the teeth, and any services intended to replace existing restorations done historically for Cosmetic reasons, even if due to material failure (wear/chipping/fracture) or the presence of decay at the restorative margin. This exclusion does not apply to services for Reconstructive Surgery. However, to the extent that these Reconstructive Surgery services are paid as medical services under the Certificate, they are not covered as pediatric dental services.
- Local anesthesia or use of electronic analgesia billed as a separate procedure is not covered. Inhaled nitrous oxide is not covered. General anesthesia and intravenous sedation are not covered except as indicated in this Benefits Chart.
- Orthodontic services, except as provided in this Benefits Chart

- Procedures, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (including chipping or fractures of tooth structure or restorations), or erosion, abfraction, abrasion, or realigning teeth, [except as covered Orthodontic services provided in this Benefits Chart.] Mandibular orthopedic appliances and bite planes are also not covered.
- Procedures, appliances (other than occlusal guards, as indicated in this section) or restorations for the prevention of bruxism (grinding of teeth) or clenching
- Services for the replacement of any missing, lost or stolen dental or implant-supported prosthesis
- Replacement or repair of Orthodontic appliances.
- Diagnostic testing that is performed by a dentist and billed as a separate procedure such as collection of microorganisms for culture, viral cultures, genetic testing for susceptibility or oral disease and caries susceptibility tests.
- For Out-of-Network coverage, dental services related to the replacement of any teeth missing prior to the Insured's effective date under this Certificate. An existing dental implant will be treated as an existing tooth and will not be considered a missing tooth.
- The portion of a billed Charge for an otherwise Covered Service by an Out-of-Network Provider, which is in excess of our maximum amount allowed.
- Except where expressly addressed in this section, when multiple, acceptable treatment options exist related to a specific dental problem, we will provide benefits based upon the least costly alternative treatment. This includes inlay restorations paid as corresponding amalgam restorations.
- Athletic mouthguards
- Charges for infection control, sterilization and waste disposal
- Cone beam CT capture and interpretation for pediatric dental services
- The surgical placement of a dental implant body and all associated dental implant-related services to replace missing primary natural teeth or congenitally missing permanent natural teeth
- Charges for interim or custom abutments for implants
- Services that assist in treatment planning and implant case planning
- Diagnostic casts, other than for Medically Necessary Orthodontic treatment
- Harvest of bone for use in autogenous grafting procedure
- Charges for maxillofacial prosthetics
- Charges for case presentations for treatment planning or behavioral management
- Charges for enamel microabrasion, odontoplasty and pulpal regeneration
- Charges for surgical procedures for isolation of a tooth with a rubber dam
- Non-intravenous conscious sedation and drugs to treat anxiety or pain
- Charges for intentional reimplantation (including necessary splinting)
- Charges for canal preparation and fitting of preformed dowel or post
- Charges for temporary crowns for fractured teeth
- Charges for rebonding, recementing and repair of fixed retainers
- Charges for surgical placement of a temporary anchorage device
- Charges for autogenous or nonautogenous osseous, osteoperiosteal or cartilage graft of the mandible or maxilla
- Charges for anatomical crown exposure
- Interim prostheses
- Provisional pontics, crowns and retainer crowns
- Copings
- Oral hygiene instruction
- Removal of fixed space maintainers
- Treatment for correction of malocclusion of teeth and associated dental and facial disharmonies, and post-treatment retainers, when treatment is not Medically Necessary
- Caries risk assessment and documentation
- Charges for unspecified procedures
- Charges for the placement of a restorative foundation for an indirect restoration

DIABETES AND HYPERTENSION DISEASE MANAGEMENT PROGRAM

Covered Services:

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

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

DIABETIC EQUIPMENT AND SUPPLIES

Covered Services:

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

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

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

Network Benefits	Out-of-Network Benefits
Pumps received through a pharmacy: 70% of the Charges incurred. Deductible does not apply. **Pumps received through a non-pharmacy Provider:** 70% of the Charges incurred if purchased from an approved vendor.	50% of the Charges incurred.

All other diabetic durable equipment and supplies

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

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

Network Benefits	Out-of-Network Benefits
If received through a pharmacy: 70% of the Charges incurred. Deductible does not apply. **If received through a non-pharmacy Provider:** 70% of the Charges incurred if purchased from an approved vendor.	50% of the Charges incurred.

Limitations:

- No more than a 93-day supply of diabetic supplies is covered and dispensed at a time
- Diabetic supplies and equipment are limited to certain models and brands. Our Commercial Diabetic Drug List includes information on required models and brands.
- Durable medical equipment and supplies must be obtained from or repaired by approved vendors
- Certain diabetic supplies and equipment must be purchased at a pharmacy

Not Covered:

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

DIAGNOSTIC IMAGING SERVICES

Covered Services:

This benefit applies to diagnostic imaging, 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
70% 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
70% 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 account at HealthPartnersUnityPointHealth.com or call Member Services to determine if additional Coverage Criteria Policies apply.

- Durable medical equipment and services, prosthetics, orthotics, and supplies, including certain disposable supplies and 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
70% of the Charges incurred. Deductible does not apply.	50% of the Charges incurred.

Oral amino acid based elemental formula

Network Benefits	Out-of-Network Benefits
70% of the Charges incurred.	50% of the Charges incurred.

Prosthetic limb devices to replace in whole or in part, an arm or leg

Network Benefits	Out-of-Network Benefits
80% of the Charges incurred. Deductible does not apply.	50% of the Charges incurred.

All other durable medical equipment, prosthetics, orthotics and supplies

Network Benefits	Out-of-Network Benefits
70% of the Charges incurred.	50% of the Charges incurred.

Limitations:

Coverage of durable medical equipment is limited by the following:

- No more than a 93-day supply of 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 items
- Labor and related Charges for repair of any covered items which are more than the cost of replacement by an approved vendor
- Charges for repair estimates, sales tax billed separately, mailing, delivery Charges, and service call Charges
- Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience, recreation or safety
- 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
- Hearing aids and hearing devices (implantable and external, including osseointegrated devices or bone anchored hearing aids/BAHA) and their fitting. This exclusion does not apply to cochlear implants, including implant batteries and replacement of external parts.
- 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 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

EMERGENCY AND URGENTLY NEEDED CARE SERVICES

Covered Services:

We cover services for Emergency Care and Urgently Needed Care if the services are otherwise eligible for coverage under this Benefits Chart.

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

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

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

Urgently needed care at clinics

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

Emergency Care Services. These are services to treat: (1) the sudden, unexpected onset of Illness or Injury which, if left untreated or unattended until the next available clinic or office hours, would result in hospitalization, or (2) a condition requiring professional health services immediately necessary to preserve life or stabilize health; or (3) with respect to a pregnant individual having contractions, that there is inadequate time to safely transfer the individual to another Hospital for delivery or that a transfer may pose a threat to the health or safety of the individual or unborn child. Emergency care services include emergency services as defined in Division BB, Title I, Section 102 of the Consolidated Appropriations Act of 2021. Emergency care services also include 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 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
100% of the Charges incurred, subject to your Copayment of $500 per visit. Deductible does not apply. Emergency room Copayment is waived if admitted for the same condition within 24 hours.	See Network Benefits. The amount you pay for these services will be determined based on the requirements of the No Surprises Act and its implementing regulations.

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

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

GENDER AFFIRMING CARE

Definitions:

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

Covered Services:

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

Log on to your account at HealthPartnersUnityPointHealth.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 account at HealthPartnersUnityPointHealth.com or call Member Services for more information.

HEALTH EDUCATION

Covered Services:

We cover education for Preventive Services and education for the management of chronic health problems (such as diabetes). Coverage includes 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.

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

HOME HEALTH SERVICES

Covered Services:

We cover the following services:

- Skilled nursing treatment in the home intended to provide a safe transition from other levels of care
- Physical therapy, occupational therapy, speech therapy, respiratory therapy and other therapeutic services

- Non-routine prenatal and postnatal services
- Routine postnatal well-child visits
- Phototherapy services for newborns
- Home health aide services and other eligible home health services when provided in your home if you are homebound (i.e., unable to leave home without considerable effort due to a medical condition). Lack of transportation does not constitute homebound status.
- Total parenteral nutrition/intravenous (TPN/IV) therapy, equipment, supplies and drugs in connection with IV therapy. IV line care kits are covered under the "Durable Medical Equipment" section. You do not need to be homebound to receive total parenteral nutrition/intravenous (TPN/IV) therapy or routine postnatal visits.
- Palliative care benefits. Palliative care includes symptom management, education and establishing goals of care. We waive the requirement that you be homebound for palliative care if you have a serious illness or life-limiting condition.

For phototherapy services for newborns and high risk prenatal services, supplies and equipment are included.

Medically Necessary home health services are eligible for coverage only when all of the following are met:

- 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 account at HealthPartnersUnityPointHealth.com or call Member Services to determine if additional Coverage Criteria Policies apply.

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

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $30 per visit. Deductible does not apply.	50% of the Charges incurred.

If more than one home health visit occurs in a day, a separate Copayment applies to each 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.	50% of the Charges incurred.

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.

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

HOSPICE SERVICES

Definitions:

Hospice Program. This is a coordinated program of 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 hospice treatment plan.

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

Continuous Care. This is from 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.

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

Covered Services:

We cover the services described below if you are terminally ill and accepted as a Hospice Program participant. You must meet the eligibility requirements of the program, and elect to receive services through the Hospice Program. 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 Hospice Program.

Eligibility. In order to be eligible to be enrolled in the 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 Hospice Program at any time.

Eligible services. Hospice services include the following services provided in accordance with an approved hospice treatment plan.

- Medically Necessary Inpatient services in a hospice Facility
- 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
- 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
70% of the Charges incurred.	50% of the Charges incurred.

Respite care is limited to five episodes, up to five days per episode. Inpatient hospice services are limited to 15 days per lifetime.

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

Not Covered:

- 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 hospice residential Facility
- Costs related to Inpatient confinement when care rendered by the Facility is Custodial
- Bereavement counseling

HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Definitions:

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

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

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

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

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

Reconstructive Surgery. This is limited to reconstructive surgery, incidental to or following surgery, resulting from Injury or Illness of the involved part, or to correct a congenital disease or anomaly resulting in a functional defect in a Dependent Child. A functional defect is one that interferes with your ability to perform activities of daily living.

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

Covered Services:

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

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

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

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

Services for items for personal convenience, such as television rental, are not covered.

Group health plans and health insurance issuers generally may not, under the Newborns and Mothers' Health Protection Act (NMHPA), restrict benefits for any Hospital length of stay in connection with childbirth for the mother of newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section, excluding day of delivery. 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). A post-discharge follow-up visit is covered under the "Home Health Services" section under "Routine postnatal well child visits".

Network Benefits	Out-of-Network Benefits
70% 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, Reconstructive Surgery, dialysis, radiation therapy, physical therapy, drugs administered during treatment, administration of Specialty Drugs, blood and blood products (unless replaced), blood derivatives, and other diagnostic or treatment related Outpatient services; Physician and other professional medical and surgical services provided while an Outpatient, including gender affirming (confirmation) surgery that meets criteria in our Coverage Criteria Policies.

Network Benefits	Out-of-Network Benefits
70% of the Charges incurred.	50% of the Charges incurred.

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

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. We also cover the costs of skilled nursing care in a Hospital if the level of care needed by the Insured has been reclassified from acute care to skilled nursing care and no designated skilled nursing care beds or swing beds are available in the Hospital or in another Hospital or health care Facility within a thirty-mile radius of the Hospital. Log on to your account at HealthPartnersUnityPointHealth.com or call Member Services to determine if additional Coverage Criteria Policies apply.

Network Benefits	Out-of-Network Benefits
70% of the Charges incurred.	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 account at HealthPartnersUnityPointHealth.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
70% of the Charges incurred.	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, services 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

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

All other laboratory services

Services for Illness or Injury

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

Preventive services

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

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.

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 pharmacist. Log on to your account at HealthPartnersUnityPointHealth.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
- Obstetric/gynecological (OB/GYN) services
- 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.
- Allergy testing based on established Coverage Criteria Policies

Log on to your account at HealthPartnersUnityPointHealth.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-visit 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 your Copayment of $30 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 your Copayment of $60 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 your Copayment of $15 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 your 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 your 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 logging on to your account at HealthPartnersUnityPointHealth.com or by calling Member Services.

Not Covered:

- Court-ordered services
- 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
70% 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 our 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 AND SPEECH THERAPY

Definitions:

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

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

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 onto your account at HealthPartnersUnityPointHealth.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 your Copayment of $30 per visit. Deductible does not apply.	50% of the Charges incurred.

Habilitative care

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $30 per visit. Deductible does not apply.	50% of the Charges incurred.

Not Covered:

- Massage therapy, except as described above
- Maintenance Care

PRE-DIABETES DISEASE MANAGEMENT PROGRAM

Covered Services:

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

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

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

PRESCRIPTION DRUGS

Definitions:

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

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

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

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 our 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 our Pharmacy and Therapeutics Committee to establish coverage. This process may take up to six months after market availability.

We are offered rebates for certain drugs from drug manufacturers. Any rebates we receive will be retained by us. The rebates will not be allocated to your specific group or to your specific claims and they will not be considered when determining your Copayment/Coinsurance.

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 account at HealthPartnersUnityPointHealth.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 account at HealthPartnersUnityPointHealth.com or call Member Services to determine if additional Coverage Criteria Policies apply.

We cover Prescription Drugs and medications, which 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.

If a Copayment is required, you must pay one Copayment for each 31-day supply, or portion thereof, unless otherwise indicated below.

Outpatient drugs (except as specified below)

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred, subject to your Copayment of $15 for Generic Formulary Drugs and $50 for Brand Name Formulary Drugs. In no event will your cost for a Formulary insulin drug exceed $25. Non-Formulary Drugs are covered at 100% of the Charges incurred, subject to your Copayment of $100. Deductible does not apply.	50% of the Charges incurred.

Mail order drugs

Network Benefits	Out-of-Network Benefits
For your convenience, you may also get up to a 93-day supply of Outpatient Prescription Drugs that can be self-administered through the designated mail order service. Specialty Drugs are not available through the mail order service.	Mail order drugs are only available through the designated mail order service. See Network mail order drugs benefit.

Specialty Drugs that are self-administered

Network Benefits	Out-of-Network Benefits
80% of the Charges incurred, up to a maximum Copayment of $300. Deductible does not apply. 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.

Growth deficiency drugs

Network Benefits	Out-of-Network Benefits
70% of the Charges incurred. Deductible does not apply. For Network Benefits, growth deficiency drugs must be obtained from a designated vendor.	50% of the Charges incurred.

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

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

Limitations:

- Certain drugs may require prior authorization or have quantity limits. We 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 account at HealthPartnersUnityPointHealth.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. We 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, the drug will be paid at the Non-Formulary benefit.
- We may require Insureds to try Over-the-Counter (OTC) drug alternatives before approving more costly Formulary Prescription Drugs
- Unless otherwise specified in the "Prescription Drugs" section, you may receive up to a 31-day supply per prescription
- A 93-day supply will be covered and dispensed only at pharmacies that participate in our extended day supply program

- New prescriptions to treat certain chronic conditions are limited to a 31-day supply
- No more than a 31-day supply of Specialty Drugs will be covered and dispensed at a time, unless it is a manufacturer supplied drug that cannot be split that supplies the Insured with more than a 31-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 drugs that are determined to be Medically Necessary
- All drugs used for the treatment of sexual dysfunction
- Medical foods, unless listed on the Formulary and prescribed by a Physician or legally authorized Health Care Provider under applicable state and federal law
- 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 HealthPartnersUnityPointHealth.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 health care services that include screenings, check-ups and counseling to prevent Illness, disease or other health problems before symptoms occur.

Covered Services:

We cover Preventive Services 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 (USPSTF) with respect to the individual
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration
- With respect to women, preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration

Log on to your account at HealthPartnersUnityPointHealth.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 use 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 (including HPV immunizations), developmental assessments and laboratory services appropriate to the age of the child from birth to 72 months and appropriate immunizations for children age 18 or younger.

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 or 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.

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.	50% of the Charges incurred.

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). For females whose family history is associated with an increased risk for BRCA1 or BRCA2 gene mutations, we cover genetic counseling and BRCA screening without cost sharing, if appropriate and as determined by a Physician.

Network Benefits	Out-of-Network Benefits
100% of the Charges incurred. 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 services:

Routine eye and hearing exams

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:

- 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.

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
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.

UnityPoint Health Virtual Care: This is a virtual consult that you may use to receive a diagnosis and treatment for a variety of medical issues through secure video on your computer or phone. You may access the Virtual Care website at unitypointvirtualcare.org.

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 your Copayment of $15 per visit. Deductible does not apply.	50% of the Charges incurred.

UnityPoint Health Virtual Care – available at unitypointvirtualcare.org

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 or Urgent Care.	Not applicable.

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 your Copayment of $15 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:

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

We cover eligible Transplant Services (as defined above) while you are covered under the Certificate. Transplants that will be considered for coverage are limited to the following:

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

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

Log on to your account at HealthPartnersUnityPointHealth.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**
70% of the Charges incurred.	50% of the Charges incurred.

Not Covered:

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

TRAVEL BENEFIT

Covered Services:

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

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

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

Benefits
70% of the Charges incurred. Expenses for travel and lodging for the Insured (the recipient) and one adult companion may be covered up to a maximum of $10,000 per transplant or CAR-T therapy. Commercial lodging reimbursement (as may be adjusted by IRS rules) is limited to a maximum of $50 per night if the Insured travels alone or a maximum of $100 per night if the Insured travels with a companion.

Not Covered:

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

WEIGHT LOSS SURGERY OR BARIATRIC SURGERY

Covered Services:

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

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

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

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

SERVICES NOT COVERED

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

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

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

CERTIFICATIONS/EXAMINATIONS

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

- To get or keep a job, including vocational assessments
- Required under a labor agreement or other contract
- Needed for legal proceedings. This includes, but is not limited to, services related to custody evaluations, parenting assessments, adoption studies, reports to the court, risk assessments for sexual offenses, educational classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) competency evaluations
- For purposes of insurance
- To get or keep a license

DENTAL SERVICES

- Dental treatment, procedures or services not described under the "Dental Services" section or in the "Dental Services - Pediatric Dental" 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
- Oral surgery to remove wisdom teeth, except as stated in the "Dental Services - Pediatric Dental" section
- Orthognathic treatment or procedures and all related services

HEARING SERVICES

- 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.
- Hearing aids and hearing devices (implantable and external, including osseointegrated devices or bone anchored hearing aids/BAHA) and their fitting. This exclusion does not apply to cochlear implants, including implant batteries and replacement of external parts.

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 prostheses (wigs)

PROVIDERS/NETWORK

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

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

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 exclusion 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 the Certificate
- 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 OR DENTALLY 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 or Dentally Necessary Care as explained in the "General Definitions" section
- Services primarily educational in nature, including, but not limited to, non-medical 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. This 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

- Acupuncture
- Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders, including Applied Behavior Analysis (ABA), Intensive Early Intervention Behavior Therapy (IEIBT), and Lovaas
- 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. Log on to your account at HealthPartnersUnityPointHealth.com or call Member Services for more information.
- Rest and respite services, including all services and medical equipment provided for such care, except as described under the "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

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

- For Network Benefits, all services for weight loss surgery or bariatric surgery not received from a Designated Weight Loss Surgery Provider. Covered Services provided by a Network Facility or Physician who is not a Designated Weight Loss Surgery Provider will be covered under the Out-of-Network Benefits. If you reside outside of the region of Designated Weight Loss Surgery Providers, we will work with you to find an approved Network Provider.
- 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 the Certificate.
- Non-medical or non-dental administrative costs, including, but not limited to:
  - Medical or dental record preparation or mailing
  - Appointment cancellation fees
  - After hours appointment charges
  - Interest charges
  - Sales tax

- Charges for phone, data, software or mobile applications/apps unless described as covered in our Coverage Criteria Policies for the device or service
- Treatment, procedures, services, supplies or drugs received when you are not covered under the Certificate
- Services from Providers who waive Copayment, Deductible and Coinsurance payments by the Insured, except in cases of undue financial hardship
- Services that are provided to you, if you also have other primary insurance coverage for those services and you do not provide us the necessary information to pursue Coordination of Benefits, as required under the Certificate.
- Charges for, or in connection with, an Injury or Illness which arises out of, or in the course of, any employment (including self-employment) for wage or profit, or for which the individual is entitled to benefits under any Workers' Compensation Law, Occupational Disease Law or similar legislation
- Services that would not otherwise be charged if you did not have health plan coverage
- Services you have no legal obligation to pay
- Replacement of Prescription Drugs, equipment and supplies due to loss, damage or theft
- Autopsies
- Financial or legal counseling services
- Housekeeping or meal services
- Duplicate charges or charges for duplicate services
- Services or items prohibited by law in the applicable jurisdiction in which they are received