CLAIMS PAYMENT POLICIES & OTHER INFORMATION

A. OUT OF NETWORK LIABILITY AND BALANCE BILLING

For covered services delivered by non-network providers, our payment is based on a percentage of the Medicare fee schedule (usual and customary charge), minus any applicable deductible, copayment or coinsurance.

The usual and customary charge is the maximum amount allowed that we consider in the calculation of payment of charges incurred for certain covered services. It is consistent with the charge of other providers of a given service or item in the same region. You must pay for any charges above the usual and customary charge, and they do not apply to the out-of-pocket limit.

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

B. ENROLLEE CLAIMS SUBMISSION

How to File a Claim:
If you receive service from a network provider, the provider will submit the claim to us on your behalf.

If you receive services from a non-network provider, you can ask if they will submit the claim to us on your behalf. If they won't you can send the claim to directly to us.

To file a claim directly with us, follow these steps:

- Members with a web account may submit claims for non-network providers directly through their web account. https://www.healthpartners.com/my/claims-reimbursement/out-of-network/
- Members without a web account may submit a paper claim.

  Claims may be sent to:
  HealthPartners Insurance Company
  8170 33rd Avenue South, P.O. Box 1289
  Minneapolis, MN 55440-1289
  For questions, please contact us at: 952-883-5000

Your submission **must** include the following:

- The plan member's name and member ID number written on each document
- Date(s) of service.
- Place of service (office, hospital, urgent care etc.)
- Care provider name
- Care provider address

- Care provider tax ID number
- Care provider phone number
- Amount billed
- For medical claims: diagnosis code(s) and procedure/CPT code(s)
- Statements, receipts and other documents

Proof of Loss. You must submit an itemized bill which documents the date and type of service, provider name and charges for covered services. Bills must be submitted within 90 days after the date services were first received. Where this section provides for payments contingent upon a period of confinement, these 90 days shall begin at the end of the period for which we are liable. If you do not furnish proof within 90 days as required, benefits shall still be paid for that loss if (1) it was not reasonably possible to give proof within those 90 days, and (2) proof is furnished as soon as reasonably possible, but no later than one year after the end of those 90 days. Any bills for covered services must be submitted to HealthPartners within 15 months of incurring the charges. Any bill received after 15 months from the date of service can be denied even if it is for a covered service unless you were unable to submit the bill because you were legally incompetent.

Time of Payment of Claims. Unless otherwise provided by law, we will make payment promptly upon receipt of due written proof of loss. Benefits which are payable periodically during a period of continuing loss shall be payable on at least a monthly basis. We will notify you of our benefit determination if you have any remaining liability within 30 days of receipt of a completed claim.

Payment of Claims. All or any portion of any benefits provided on account of hospital, nursing, medical, dental or surgical services may, at our option, be paid directly to the hospital or provider providing such services, but it is not required that the services be provided by a particular hospital or provider.

At our option, all payments for claims may be made directly to the provider of medical or dental services, rather than to the enrollee, for claims incurred by a child, who is covered as a dependent of an enrollee who has legal responsibility for the dependent's medical or dental care pursuant to a court order, provided we are informed of such order. This payment will discharge us from all further liability to the extent of the payment made.

Legal Action. No legal action may be taken on claims until 60 days after the bills have been submitted, nor more than three years after due proof of loss is required to be submitted.

C. GRACE PERIODS AND CLAIMS PENDING POLICIES

The grace period is a payment of time after your monthly health insurance premium is due before your insurance could end. The grace period is usually 90 days if you have marketplace coverage and qualify for advance payments of the premium tax credit, and you've paid at least on full month's premium.

Coverage under this Policy is conditioned on our regular receipt of the enrollee's premium payments. Premium payments are based upon the policy type and the number and status of any dependents enrolled with the enrollee. Premium payments do not take into account the claim experience or any change in health status of the enrollee, which occurs after the initial issuance of this Policy. Your premium payments usually change annually on your Renewal Date (which may be different than your

effective date), subject to 60 days' notice. The Renewal Date of the Policy may be subject to change. HealthPartners will default your premium payments to a pre-payment, mailed paper statement, on a monthly cycle.

The premium payment is due on or before the 1st of each month that coverage is provided. There is a 10-day grace period during which to pay the required premium. Coverage under this Policy will continue in force during the grace period. If no payment is received by us within the 10-day grace period, coverage terminates retroactive to the paid through date.

If you are a recipient of advance payment of the premium tax credit, you have a 3-month grace period, provided you have paid at least one full month's premium during the benefit period. If your premium payment is late, we will send a notice stating that your coverage will terminate at the end of the first month of the three-month grace period if you do not pay your full premium within the 3-month grace period. If all premium due is not paid within the 3-month grace period, your coverage will retroactively terminate at the end of the first month of the three-month grace period in the initial termination letter. You will be responsible for payment of any services provided after the date of termination.

A claim pending means more information on the claim is needed before it can be processed. A claim is held in a pending status for processing of payment in the event that an individual has not made good on their monthly premium payment. Once the premium has been paid the claim will be released for payment. If the premium payment has not been made in the allotted time period, the contract will be cancelled for non-payment and the claims will be denied for no-coverage.

D. RETROACTIVE DENIALS

If a member receives services from a provider and HealthPartners processes and pays the claim and it is later determined that the premium payments have not been made your claims will be denied retroactively. You will then be responsible to pay the provider directly for any services you received.

In order to prevent retroactive claims denial you should always pay your monthly premium payments in the allotted time frame.

E. ENROLLEE RECOUPMENT OF OVERPAYMENT

On an active individual medical policy not purchased through a state or federal marketplace, if HealthPartners receives a payment that is greater than the current premium due, or a change to coverage results in a premium credit, no refund will be made. The credit amount will be applied to future premium amounts owed.

If you believe you have paid too much towards your premium, please contact HealthPartners Membership Accounting at 952-883-5353.
If there is a credit or overpayment on a canceled policy, the credit will be refunded to the policy holder within 4 weeks.

F. MEDICAL NECESSITY AND PRIOR AUTHORIZATION

Your physician may be required to obtain prior authorization for certain services. Your physician will coordinate the prior authorization process for any services which must first be prior authorized. You

may call Member Services or log on to your "myHealthPartners" account at healthpartners.com for a list of which services require your physician to obtain prior authorization. You also must obtain prior authorization from us to see non-network providers for the care delivered by non-network providers to be covered as Network Benefits. Our medical or dental directors, or their designees, make coverage determinations of medical necessity and make final authorization for covered services. Coverage Determinations are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors.

When a prior authorization for a service is required, we will make an initial determination within 5 business days, provided that all information reasonably necessary to make a determination on the request has been available to us. When a prior authorization for an urgent service is required, we will make an initial determination within 48 hours after the initial request unless more time is required to ensure that our time for making a determination includes at least one business day.

If we require prior authorization of a service, the following rules apply:

- If the service is ordered by a Network Provider, the Network Provider is responsible for prior authorizing the service with us. If the Network Provider does not prior authorize the service with us, we will cover the service with no reduction in benefits to you.
- If the service is ordered by a Non-Network Provider, you or the Non-Network Provider are responsible for prior authorizing the service with us. If you or the Non-Network Provider do not prior authorize the service with us, the service will be subject to a retrospective review to see if it meets the definition of medically necessary care. If it is determined to be medically necessary, it will be covered at the non-network benefit level. If it is determined to be not medically necessary, you will be responsible for the cost of the service.

G. FORMULARY EXCEPTION PROCESS

If the Individual Policy does not cover non-formulary drugs, and your physician prescribes a drug that is not on our formulary, you may request a review under the formulary exceptions process.

If you are prescribed a drug that is not included on the formulary and your Individual Policy does not cover non-formulary drugs, you, your designee or your prescribing physician may request a review through our formulary exception process which includes external review. This process is described below.

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

2. **Expedited Exception Request.** If your provider prescribes a drug that is not on our formulary, you may submit an expedited exception request if there are exigent circumstances. Exigent circumstances exist when you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course using a non-formulary drug. If you, your designee or your prescribing provider submit an expedited exception request, we must make our coverage determination and notify you within 24 hours of our receipt of the request. If we grant the exception to cover the drug, we are required to cover the drug for the duration of the prescription, including refills. If we grant an exception based on exigent circumstances, we must cover the drug for the duration of the exigency.
3. **External Review Exception Request.** If coverage of a drug is denied after an exception request review under items 1 or 2 above, you may request an external review exception request. If the initial request was a standard exception request, we must notify you or your designee and the prescribing provider of the coverage determination within 72 hours of our receipt of your request for external review. If the initial request was an expedited exception request, we must notify you or your designee and the prescribing provider of the coverage determination within 24 hours of our receipt of your request for external review.

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

H. INFORMATION ON EXPLANATION OF BENEFITS (EOBS)

An Explanation of Benefits (EOB) is sent to a member once HealthPartners has processed a claim. The EOB will break out how the bill was paid and what portion each party is responsible for.
The EOB is not a bill.
To learn about explanations of benefits or EOBs Explanation of Benefits (EOB)

I. COORDINATION OF BENEFITS

This Coordination of Benefits provision applies when the Insured has group health care coverage in addition to coverage under this Policy. The Insured's benefits under this plan are reduced so that the total benefits do not exceed 100% of covered services.

Certain facts are needed to coordinate benefits. We have the right to decide which facts we need. Consistent with applicable state and federal law, we may get needed facts from or give them to any other organization or person, without your further approval or consent unless applicable state or federal law prevents disclosure of the information without the consent of the patient or the patient's representative. Each person claiming benefits under this Policy must give us facts we need to pay the claim.

If we pay more than we should have paid under this Coordination of Benefits rule, we may recover the excess from one or more of the following:

1. the persons we paid or for whom we have paid;
2. insurance companies; or
3. other organizations.

The amount paid includes the reasonable cash value of any benefits provided in the form of services.