



Group Membership Contract

*HealthPartners Minnesota
Small Employer Plans*

TABLE OF CONTENTS

Section	Page
About HealthPartners and HealthPartners Insurance Company	1
Important Enrollee Information for Network Services	1
Enrollee Bill Of Rights for Network Services	2
Terms and Conditions of Use of This Contract	2
I. Introduction to the Group Membership Contract.....	3
A. Group Membership Contract	3
B. Identification Card	3
C. Assignment Of Benefits.....	3
D. Enrollment Payments	3
E. Benefits	3
F. Benefits Chart	4
G. Amendments To This Contract.....	4
H. Master Group Contract	4
I. Conflict With Existing Law	4
J. How to Use the Network	4
K. CareCheck®	7
L. Access to Records and Confidentiality	8
II. Definitions of Terms Used.....	8
III. Services Not Covered	11
IV. Disputes and Complaints	13
V. Conditions	17
VI. Effective Date and Eligibility.....	21
VII. Continuation of Group Coverage.....	23
VIII. Termination	25
IX. Claims Provisions	26
X. Statement of ERISA Rights	27
XI. Specific Information About the Plan	29

AMENDMENT(S)

BENEFITS CHART

HEALTHPARTNERS MISSION

***OUR MISSION IS TO IMPROVE HEALTH AND WELL-BEING IN PARTNERSHIP
WITH OUR MEMBERS, OUR PATIENTS AND COMMUNITY.***

ABOUT HEALTHPARTNERS, INC. and HEALTHPARTNERS INSURANCE COMPANY

HealthPartners, Inc. (HealthPartners). HealthPartners is a non-profit corporation which is licensed by the State of Minnesota as a Health Maintenance Organization (HMO). HealthPartners underwrites and administers the Network Benefits described in this Contract. HealthPartners is the parent company of a family of related organizations and provides administrative services for HealthPartners Insurance Company. When used in this Contract, “we”, “us” or “our” has the same meaning as “HealthPartners” and its related organizations.

HealthPartners Insurance Company. HealthPartners Insurance Company is the insurance company underwriting the Non-Network Medical Expense Benefits described in this Contract. HealthPartners Insurance Company is a part of the HealthPartners family of related organizations.

The HMO coverage described in this Contract may not cover all your health care expenses. Read this Contract carefully to determine which expenses are covered.

The laws of the State of Minnesota provide members of an HMO, certain legal rights, including the following:

IMPORTANT ENROLLEE INFORMATION FOR NETWORK SERVICES:

1. **COVERED SERVICES.** These are network services provided by participating network providers or authorized by those providers. This Contract fully defines what services are covered and describes procedures you must follow to obtain coverage.
2. **PROVIDERS.** Enrolling with HealthPartners does not guarantee services by a particular provider on the list of network providers. When a provider is no longer part of the network, you must choose among remaining Network providers.
3. **EMERGENCY SERVICES.** Emergency services from providers outside the network will be covered only if proper procedures are followed. Read this Contract for the procedures, benefits and limitations associated with emergency care from network and non- network providers.
4. **EXCLUSIONS.** Certain services or medical or dental supplies are not covered. Read this Contract for a detailed explanation of all exclusions.
5. **CONTINUATION.** You may continue coverage under certain circumstances. Read this Contract for a description of your continuation rights.
6. **CANCELLATION.** Your coverage may be cancelled by you or HealthPartners only under certain conditions. Read this Contract for the reasons for cancellation of coverage.

7. **NEWBORN COVERAGE:** If your health plan provides for dependent coverage, a newborn infant is covered from birth. HealthPartners will not automatically know of the newborn's birth or that you would like coverage under your plan. You should notify HealthPartners of the newborn's birth and that you would like coverage. If your contract requires an additional enrollment payment for each dependent, HealthPartners is entitled to all enrollment payments due from the time of the infant's birth until the time you notify us of the birth. HealthPartners may withhold payment of any health benefits for the newborn infant until any enrollment payments you owe are paid.
8. **PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT:** Enrolling with HealthPartners does not guarantee that any particular prescription drug will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the contract year.

ENROLLEE BILL OF RIGHTS FOR NETWORK SERVICES

1. Enrollees have the right to available and accessible services including emergency services 24 hours a day and seven days a week.
2. Enrollees have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice.
3. Enrollees have the right to refuse treatment, and the right to privacy of medical or dental and financial records maintained by HealthPartners and its health care providers, in accordance with existing law.
4. Enrollees have the right to file a complaint with HealthPartners and the Commissioner of Health and the right to initiate a legal proceeding when experiencing a problem with HealthPartners or its health care providers.
5. Medicare enrollees have the right to voluntarily disenroll from HealthPartners and the right not to be requested or encouraged to disenroll, except in circumstances specified in federal law.
6. Medicare enrollees have the right to a clear description of nursing home and home care benefits covered by HealthPartners.

TERMS AND CONDITIONS OF USE OF THIS CONTRACT

1. This document may be available in printed and/or electronic form.
2. Only HealthPartners is authorized to amend this document.
3. Any other alteration to a printed or electronic plan document is unauthorized.
4. In the event of a conflict between printed or electronic plan documents only the authorized plan document will govern.

HealthPartners names and logos and all related products and service names, design marks and slogans are the trademarks of HealthPartners or its related companies.

I. INTRODUCTION TO THE GROUP MEMBERSHIP CONTRACT

A. GROUP MEMBERSHIP CONTRACT

This Group Membership Contract (this Contract) is the enrollee's evidence of coverage, under the Master Group Contract issued by HealthPartners and HealthPartners Insurance Company to the enrollee's group health plan sponsor. The Master Group Contract provides for the medical and dental coverage described in this Contract. It covers the enrollee and the enrolled dependents (if any) as named on the enrollee's membership application. The enrollee and his or her enrolled dependents are our members. This Contract replaces all contracts previously issued by us.

Under this Contract, you have equal access to all health programs or activities without discrimination on the basis of sex or gender identity. We may not limit health services or impose additional cost sharing for services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.

B. IDENTIFICATION CARD

An identification card will be issued to you at the time of enrollment. You will be asked to present your identification card, or otherwise show that you are a member, whenever you seek services. You may not permit anyone else to use your card to obtain care.

C. ASSIGNMENT OF BENEFITS

You may not assign or in any way transfer your rights under this Contract.

D. ENROLLMENT PAYMENTS

This Contract is conditioned on our regular receipt of enrollees' enrollment payments. The enrollment payments are made through the enrollee's group health plan sponsor, unless we have agreed to another payment method. Enrollment payments are based upon the contract type and the number and status of any dependents enrolled with the enrollee.

Please refer to the most recent enrollment material for information regarding contributions to your plan which is hereby incorporated by this reference.

E. BENEFITS

This Contract provides **comprehensive Network Benefits (Network Benefits)** underwritten by HealthPartners, for medical and dental services delivered by participating network providers or authorized by us. This Contract describes your Network Benefits and how to obtain covered services.

This Contract also provides **Non-Network Medical Expense Benefits (Non-Network Benefits)**, underwritten by HealthPartners Insurance Company for medical and dental services delivered by non-network providers. This coverage is in addition to your comprehensive network coverage under this Contract. It is not used to fulfill the comprehensive HMO coverage required by law. This Contract describes your Non-Network Benefits and how to obtain covered services.

Pediatric services will be covered until at least the end of the month in which the member turns 19.

You may be required to get prior authorization from CareCheck® before using certain benefits. There may be a reduction of benefits available to you, if you do not get prior authorization for those services. See "CareCheck®" in this Contract for specific information about prior authorization.

When you access certain Network Benefits, the benefits may be applied toward your maximum benefit limits under Non-Network Benefits. When you access certain Non-Network benefits, the benefits may be applied toward your maximum benefit limits under the Network Benefits. See the Benefits Chart to determine which benefit limits apply to Network Benefits and/or Non-Network Benefits.

F. BENEFITS CHART

Attached to this Contract is a Benefits Chart, which is incorporated and fully made a part of this Contract. It describes the amounts of payments and limits for the coverage provided under this Contract. Refer to your Benefits Chart for the amount of coverage applicable to a particular benefit. These benefits are further described in section III.

G. AMENDMENTS TO THIS CONTRACT

Amendments which we include with this Contract or send to you at a later date are incorporated and fully made a part of this Contract.

H. MASTER GROUP CONTRACT

The HealthPartners Master Group Contract combined with this Contract, any Amendments, the group health plan sponsor's application, the individual applications of the enrollees and any other document referenced in the Master Group Contract constitute the entire contract between HealthPartners and HealthPartners Insurance Company and the group health plan sponsor. This Master Group Contract is available for inspection at your group health plan sponsor's office or at HealthPartners' and HealthPartners Insurance Company's home office, at 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309. The Master Group Contract is delivered in the State of Minnesota and governed by the laws thereof.

I. CONFLICT WITH EXISTING LAW

In the event that any provision of this Contract is in conflict with Minnesota or federal law, only that provision is hereby amended to conform to the minimum requirements of the law.

J. HOW TO USE THE NETWORK

This provision contains information you need to know in order to obtain network benefits.

This Contract provides coverage for your services provided by our network of participating providers and facilities.

Designated Physician, Provider or Facility: This is a current list of network physicians, providers or facilities which are authorized to provide certain covered services as described in this contract. Call Member Services for a current list.

Network Provider. This is any one of the participating licensed physicians, dentists, mental and chemical health or other health care providers, facilities and pharmacies listed in your network directory, which has entered into an agreement with HealthPartners to provide health care services to members.

You can view a provider directory at any time by logging on to your "myHealthPartners" account at www.healthpartners.com. You may also call Member Services and request a paper copy.

For groups subject to ERISA, a provider listing will be sent to you automatically, and free of charge, as a separate document along with the Membership Contract.

Emergency care is available 24 hours a day, seven days a week.

Non-Network Providers. These are licensed physicians, dentists, mental and chemical health or other health care providers, facilities and pharmacies not participating as network providers.

ABOUT THE NETWORK

To obtain Network Benefits for covered services, you must select and receive services from your network providers. To go to a non-network provider, you must receive authorization from us for these services to be covered as Network Benefits. There are limited exceptions as described in this Contract.

Network. This is the network of participating network providers described in the network directory.

Network Clinics. These are participating clinics providing ambulatory medical and dental services.

HealthPartners Service Area. This is the geographical area in which HealthPartners provides services to members. Contact Member Services for information regarding the service area.

Second Opinions for Network Services. If you question a decision about medical or dental care, we cover a second opinion from a Network physician or dentist.

If you question the decision made by a Network mental health professional concerning treatment for alcohol or drug abuse or mental health services, we cover a second opinion from another Network mental health professional at your request. The coverage decision will not be final until the second HealthPartners provider is seen. If the determination is that no outpatient or inpatient treatment is necessary, you may request another opinion from a qualified non-network mental health professional and we will pay for such an opinion. We will consider the opinion of the non-network mental health professional, but are not obligated to accept or act upon the recommendations made by such professional.

Continuity of Care. In the event you must change your current primary care physician, specialty care physician or general hospital provider because that provider leaves the HMO network or because your employer changed health plan offerings, you may have the right to continue receiving services from your current provider for a period of time. Some services provided by non-network providers may be considered a covered HMO benefit for up to 120 days under this contract if you qualify for continuity of care benefits.

Conditions that qualify for this benefit are:

1. an acute condition;
2. a life-threatening mental or physical illness;
3. pregnancy beyond the first trimester of pregnancy;
4. a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or
5. a disabling or chronic condition that is in an acute phase.

You may also request continuity of care benefits for culturally appropriate services or when we do not have a provider who can communicate with you directly or through an interpreter. Terminally ill patients are also eligible for continuity of care benefits.

Call Member Services for further information regarding continuity of care benefits.

Referrals and Authorizations for Network Services.

There is no referral requirement for services delivered by providers within your network. Your physician may be required to obtain prior authorization for certain services. Your physician will coordinate the authorization process for any services which must first be authorized. You may call the Member Services Department or log on to your “myHealthPartners” account at www.healthpartners.com for a list of which services require your physician to obtain prior authorization. You also must obtain 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 and dental necessity and dental and make final authorization for covered services. Coverage Determinations are based on established medical and dental policies, which are subject to periodic review and modification by the medical or dental directors.

When an authorization for a standard service is required, we will make an initial determination within 10 business days, so long as all information reasonably needed to make the decision has been provided. If we request additional information, you have up to 45 days to provide the information requested. If the additional information is not received within 45 days, a coverage determination will be made based on the information available.

When an authorization for an urgent service is required, we will make an initial determination within 72 hours, so long as all information reasonably needed to make a decision has been provided. In the event that you have not provided all information necessary to make a decision, you will be notified of such failure within 24 hours. You will have up to 48 hours to provide the information requested. If the additional information is not received within 48 hours, a coverage determination will be made based on the information available.

If the determination is made to approve the service, we will notify your health care provider by telephone, and may send written verification.

If the initial determination is made not to approve the service, we will notify your health care provider and hospital, if appropriate, by telephone within one working day of the determination, and we will send written verification with details of the denial.

If you want to request an expedited review, or have received a denial of an authorization and want to appeal that decision, you have a right to do so. If your complaint is not resolved to your satisfaction in the internal complaint and appeal process, you may request an external review under certain circumstances. Refer to the information regarding Appeals Involving Medical Necessity Determinations and CareCheck® Decisions in section V. "Disputes and Complaints" for a description of how to proceed.

Your physician will obtain an authorization for (1) residential care for the treatment of eating disorders as an alternative to inpatient care in a licensed facility when medically necessary; (2) psychiatric residential treatment for emotionally disabled children; and (3) mental health services provided in the home.

Contracted convenience care clinics are designated on our website when you log on to your "myHealthPartners" account at www.healthpartners.com. You must use a designated convenience care clinic to obtain the convenience care benefit shown in your Benefits Chart.

Scheduled telephone visits must be provided by a designated, network provider.

Durable medical equipment and supplies must be obtained from or repaired by approved vendors.

Non-emergent, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) must be provided at a designated facility. Your physician or facility will obtain or verify authorization for these services with HealthPartners, as needed.

All services for the purpose of weight loss must be provided by a designated physician. Your physician or facility will obtain or verify authorization for these services with HealthPartners, as needed.

Multidisciplinary pain management must be provided at designated facilities. Your physician or facility will obtain authorization for these services from HealthPartners, as needed.

Psychiatric residential treatment for emotionally disabled children must be provided at designated facilities. Your physician or facility will obtain authorization for these services from HealthPartners, as needed.

For specialty drugs that are self-administered, you must obtain the specialty drugs from a designated vendor to be covered as HealthPartners Benefits. Coverage is described in the Benefits Chart.

Call Member Services for more information on authorization requirements or approved vendors.

K. CARECHECK® (Applicable to Non-Network Benefits only)

It is your responsibility to notify CareCheck® of all services requiring review, as shown in 1. below. Failure to follow CareCheck® procedures may result in a reduction of the amount otherwise payable to you under this Contract. You can designate another person to contact CareCheck® for you.

- 1. CARECHECK® Services.** CareCheck® is HealthPartners' utilization review program. CareCheck® must precertify all inpatient confinement and same day surgery, new, experimental or reconstructive outpatient technologies or procedures, durable medical equipment or prosthetics costing over \$3,000, home health services after your visits exceed 30, and skilled nursing facility stays.
- 2. Procedure To Follow To Receive Maximum Benefits**
 - a. For medical emergencies.** A certification request is to be made by phone to CareCheck® as soon as reasonably possible after the emergency. You will not be denied full coverage because of your failure to gain certification prior to your emergency.
 - b. For medical non-emergencies.** A phone call must be made to CareCheck® when services requiring precertification are scheduled, but not less than 2 working days prior to that date. CareCheck® advises the physician and the hospital, or skilled nursing facility, by phone, if the request is approved. This will be confirmed by written notice within ten business days of the request.
- 3. Failure to Comply With CareCheck® Requirements.** With respect to Non-Network Benefits, if you fail to make a request for precertification of services in the time noted above, but your services requiring precertification are subsequently approved as medically necessary, we will reduce the eligible charges by 20%.
- 4. CareCheck® Certification Does Not Guarantee Benefits.** CareCheck® does not guarantee either payment or the amount of payment. Eligibility and payment are subject to all of the terms of the Contract.
- 5. Information Needed When You Call CareCheck®**

When you or another person contacts CareCheck®, this information is needed:

- the enrollee's name, address, phone number and member number;
- the patient's name, birth date, the relationship to the enrollee and the patient's member number;
- the attending physician's name, address, and phone number;
- the facility's name, address, and phone number;
- the reason for the inpatient admission and/or proposed surgical procedure.

6. Pre-certification Process.

When a pre-certification for a non-urgent service is requested from HealthPartners, an initial determination must be made within 15 calendar days. This time period may be extended for an additional 14 days, provided that we determine that such extension is necessary due to matters beyond our control. If such extension is necessary, you will be notified prior to the expiration of the initial 15-day period.

When a pre-certification for an urgent service is requested from HealthPartners, an initial determination must be made within 72 hours, so long as all information reasonably needed to make a decision has been provided. In the event you have not provided all information necessary to make a decision, the you will be notified of such failure within 24 hours. Then you will then be given 48 hours to provide the requested information. The you will be notified of the benefit determination within 48 hours after the earlier of HealthPartners receipt of the complete information or the end of the time granted to the you to provide the specified additional information.

If the determination is made to approve, we will notify your health care provider by telephone, and may send written verification.

If the initial determination is made not to approve, we will notify your health care provider and hospital, if appropriate, by telephone within one working day of the determination, and we will send written verification with details of the denial.

If you want to request an expedited review, or have received a denial of a pre-certification and want to request an appeal, you have a right to do so. If your complaint is not resolved to your satisfaction under certain circumstances, you may request an external review. Refer to the information regarding Appeals Involving Medical Necessity Determinations and CareCheck® Decisions in section V. "Disputes and Complaints" for a description of how to proceed.

How to contact CareCheck®: You may call (952)-883-6400 in the Minneapolis/St. Paul metro area or 1-800-316-9807 outside the metro area from 8:00 a.m. to 5:00 p.m. (Central Time) weekdays. You can leave a recorded message at other times. You may also write CareCheck® at Quality Utilization Management Department, 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

L. ACCESS TO RECORDS AND CONFIDENTIALITY

We comply with the state and federal laws governing the confidentiality and use of protected health information and medical or dental records. When your provider releases health information to us according to state law, we can use your protected health information, when necessary, for certain health care operations, including, but not limited to: claims processing, including claims we make for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, case management, care coordination and utilization management, disease management, premium rating, claims experience reporting to your employer or other health plan sponsor; (only upon certification by your employer or plan sponsor of the compliance of plan documents with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")), the evaluation of potential or actual claims against us, auditing and legal services, and other access and use without further authorization if permitted or required by another law. When you enrolled for coverage, you authorized our access to use your records as described in this paragraph, and this authorization remains in effect unless it is revoked.

II. DEFINITIONS OF TERMS USED

Actively at work. This is the time period in which an enrollee is customarily performing all the regular duties of his/her occupation, at the usual place of employment or business, or at some location to which that employment requires travel. An enrollee is considered actively at work for the time period absent from work solely by reason of vacation or holiday, if the enrollee was actively at work on the last preceding regular work day.

Admission. This is the medically necessary admission to an inpatient facility for the acute care of illness or injury.

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.

CareCheck® Service. This is a pre-certification and utilization management program. It reviews, authorizes and coordinates the appropriateness and quality of care for certain services for members, as covered in the Non-Network Benefits of this Contract.

CareLineSM Service. This is a service which employs a staff of registered nurses who are available by phone to assist members in assessing their need for medical care, and to coordinate after-hours care, as covered in this Contract.

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.

Convenience Clinic. This is a clinic that offers a limited set of services and does not require an appointment.

Cosmetic Surgery. This is surgery to improve or change appearance (other than reconstructive surgery), which is not necessary to treat a related illness or injury.

Covered Service. This is a specific medical or dental service or item, which is medically necessary or dentally necessary and covered by us, as described in this Contract.

Custodial Care. This is 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.

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. The member's general health condition must permit the necessary procedure(s). Decisions about dental necessity are made by the HealthPartners Dental Director or his or her designee.

Eligible Dependents. These are the persons shown below. Under this Contract, a person who is considered an enrollee is not qualified as an eligible dependent. A person who is no longer an eligible dependent (as defined below) on an enrollee's Contract may qualify for continuation of coverage within the group, as provided in section VII. of this Contract.

1. **Spouse.** This is an enrollee's current legal spouse. If both spouses are covered as enrollees under this Contract, only one spouse shall be considered to have any eligible dependents.
2. **Child.** This is an enrollee's (a) natural or legally adopted child (effective from the date of the adoption or the date placed for adoption, whichever is earlier); (b) child for whom the enrollee or the enrollee's spouse is the legal guardian; (c) a child covered under a valid qualified medical child support order (as the term is defined under Section 609 of the Employee Retirement Income Security Act (ERISA) and its implementing regulations) which is enforceable against an enrollee*; or (d) stepchild of the enrollee (that is, the child of the enrollee's spouse). In each case the child must be either under 26 years of age or a disabled dependent, as described below.

*A description of the procedures governing qualified medical child support order determination can be obtained, without charge, from us. Coverage will be effective on the first day of the court order.

3. **Qualified Grandchild.** This is a covered grandchild of an enrollee or an enrollee's spouse who is a newborn, and who resides with and is financially dependent on the covered grandparent. The child must be either under 26 years of age or a disabled dependent, as described below.
4. **Disabled Dependent.** This is an enrollee's dependent as referred to in 2. and 3. above, who is beyond the limiting age and physically handicapped or mentally disabled, and dependent on the enrollee for the majority of his/her financial support. The disability must have come into existence prior to attainment of age 26. Disability does not include pregnancy. "Disabled" means incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder, or physical handicap. The enrollee must give us a written request for coverage of a disabled dependent. The request must include written proof of disability and must be approved by us, in writing. We must receive the request within 31 days of the date an already enrolled dependent becomes eligible for coverage under this definition, or when adding a new disabled dependent eligible under this definition. We reserve the right to periodically review disability, provided that after the first two years, we will not review the disability more frequently than once every 12 months.

Emergency Accidental Dental Services. These are services required immediately, because of a dental accident.

Enrollee. This is a person who is eligible through the group health plan sponsor's Master Group Contract, applies for membership and is accepted by us for coverage under this Contract.

Enrollment Date. This is the first day of coverage under the Contract, or the first day of the waiting period, if earlier.

Facility. This is a licensed medical center, clinic, hospital, skilled nursing care facility or outpatient care facility, lawfully providing a medical or dental service in accordance with applicable governmental licensing privileges and limitations.

Group Health Plan Sponsor. This is the purchaser of this Contract's group medical coverage, which covers the enrollee and any eligible dependents.

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 normal motor development. To be considered habilitative, measurable functional improvement and measurable progress must be made toward achieving functional goals, within a predictable period of time toward a member's maximum potential ability.

Health Care Provider. This is any licensed non-physician (excluding naturopathic providers), lawfully performing a medical or dental service in accordance with applicable governmental licensing privileges and limitations, who renders direct patient care to our members as covered in this Contract.

Home Hospice Program. This is a coordinated program of home-based, supportive and palliative care, for terminally ill patients and their families, to assist with the advanced stages of an incurable disease or condition. The services provided are comfort care and are not intended to cure the disease or medical condition, or to prolong life, in accordance with an approved home hospice treatment plan.

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.

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 a member chooses 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.

Investigative: As determined by us, a drug, device or medical or dental treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. We will consider the following categories of reliable evidence, none of which shall be determinative by itself:

1. Whether 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); if the drug or device or medical or dental treatment or procedure is the subject of ongoing Phase I, II or III clinical trials; or if the drug, device or medical or dental treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and
2. Whether there are consensus opinions or recommendations in relevant scientific and medical and/or dental literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether a drug is included in any authoritative compendia as identified by the Medicare program for use in the determination of a medically necessary accepted indication of drugs and biologicals used off-label, as appropriate for its proposed use; and
3. Whether there are consensus opinions of national and local health care providers in the applicable specialty as determined by a sampling of providers, including whether there are protocols used by the treating facility or another facility studying the same drug, device, medical or dental treatment or procedure.

Medically Necessary Care. This is diagnostic testing and medical treatment which is medically appropriate to the member's physical or mental diagnosis for an injury or illness, and preventive services covered in this Contract. Medically necessary care must meet the following criteria:

1. it meets clinically accepted medical services and practice parameters of the general medical community; and
2. it is an appropriate type of service delivered at an appropriate frequency and level of care, and in an appropriate setting for the member's condition; and
3. it restores or maintains health; or
4. it prevents deterioration of the member's condition; or
5. it prevents the reasonably likely onset of a health problem or detects an incipient problem.

Medicare. This is the federal government's health insurance program under Social Security Act Title XVIII. Medicare provides health benefits to people who are age 65 or older, or who are permanently disabled. The program has two parts: Part A and Part B. Part A generally covers the costs of hospitals and extended care facilities. Part B generally covers the costs of professional medical services. Both parts are subject to Medicare deductibles.

Member. This is the enrollee covered for benefits under this Contract, and all of his or her eligible and enrolled dependents. When used in this Contract, "you" or "your" has the same meaning.

Mental Health Professional. This is a psychiatrist, psychologist, or mental health therapist licensed for independent practice, lawfully performing a mental or chemical health service in accordance with governmental licensing privileges

and limitations, who renders mental or chemical health services to our members as covered in this Contract. For inpatient services, these mental health professionals must be working under the order of a physician.

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).

Period of Confinement. This is (a) one continuous hospitalization, or (b) a series of hospitalizations or skilled nursing facility stays or periods of time when the member is receiving home health services for the same medical condition in which the end of one is separated from the beginning of the next by less than 90 days. For the purpose of this definition, "same condition" means illness or injury related to former illness or injury in that it is either within the same ascertainable diagnosis or set of diagnoses, or within the scope of complications or related conditions.

Physician. This is a licensed medical doctor, or doctor of osteopathy, lawfully performing a medical service, in accordance with governmental licensing privileges and limitations, who renders medical or surgical care to our members as covered in this Contract.

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.

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 functional defect in a dependent child, as determined by the attending physician.

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.

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 our members, whose condition requires skilled nursing facility care. It does not include facilities which primarily provide treatment of mental or chemical health.

Waiting Period. This is, for a potential member, the period that must pass before the member is eligible, under the group health plan sponsor's eligibility requirements, for coverage under this Contract.

III. SERVICES NOT COVERED

In addition to any other benefit exclusions, limitations or terms specified in this Contract, we will not cover charges incurred for any of the following services, except as specifically described in this Contract:

1. Treatment, procedures, or services or drugs which are not medically or dental necessary and/or which are primarily educational in nature or for the vocation, comfort, convenience, appearance or recreation of the member, including skills training.
2. For network coverage, treatment, procedures or services which are not provided by a network physician or other authorized network provider. There are certain exceptions, as described in "Emergency and Urgently Needed Care Services" and "Specified Non-Network Services".
3. Procedures, technologies, treatments, facilities, equipment, drugs and devices which are considered investigative, or otherwise not clinically accepted medical or dental services. We consider vagus nerve stimulator treatment for the treatment of depression and Quantitative Electroencephalogram treatment for the treatment of behavioral health conditions to be investigative and do not cover these services. We consider the following transplants to be investigative and do not cover them: surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, non-human organ implants and/or transplants and other transplants not specifically listed in this Contract.
While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered.
4. Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders, including ABA, IEIBT and Lovaas.
5. Rest and respite services, except as respite services are specifically described in the Benefits Chart under the section "Home Hospice Services" and custodial care. This includes all services, medical equipment and drugs provided for such care.
6. Halfway houses, extended care facilities, or comparable facilities, residential treatment services(except for psychiatric residential treatment for emotionally disabled children, residential care for the treatment of eating disorders and chemical health treatment in a licensed residential primary treatment center as specified in the "Behavioral Health Services" section).
7. Foster care, adult foster care and any type of family child care provided or arranged by the local state or county.
8. Services associated with non-covered services, including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies.
9. Services from non-medically or non-dentally licensed facilities or providers and services outside the scope of practice or license of the individual or facility providing the service.
10. Cosmetic surgery, cosmetic services and treatments primarily for the improvement of the member's appearance or self-esteem. This exclusion does not apply to services for port wine stain removal and reconstructive surgery.
11. Dental treatment, procedures or services not listed in this Contract.
12. Vocational rehabilitation and recreational or educational therapy. Recreation therapy is therapy provided solely for the purpose of recreation, including but not limited to: (a) requests for physical therapy or occupational therapy to improve athletic ability, and (b) braces or guards to prevent sports injuries.
13. Health services and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise medically necessary, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI), competency evaluations, and adoption studies.
14. Court ordered treatment, except as described under the Benefits Chart section B. subsection "Mental Health Services" and section Q. "Office Visits for Illness or Injury" or as otherwise required by law.
15. Reversal of sterilization, assisted reproduction, including, but not limited to gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), intracytoplasmic sperm injection (ICSI), and/or in-vitro fertilization (IVF), and all charges associated with such procedures; treatment of infertility, including but not limited to, office visits, laboratory and diagnostic imaging services and sperm, ova or embryo acquisition, retrieval or storage; however, we do cover office visits and consultations to diagnose infertility.
16. Services related to the establishment of surrogate pregnancy and fees for a surrogate are not covered. Pregnancy and maternity services are covered for a member under this Contract.
17. Routine foot care, except as they meet criteria for medically necessary care.

18. Keratotomy and keratorefractive surgeries, eyeglasses, contact lenses and their fitting, measurement and adjustment, and hearing aids (implantable and external, including osseointegrated or bone anchored) and their fitting, except as specifically described in this Contract. This exclusion does not apply to pediatric eyewear or cochlear implants, which are covered as described in the medical coverage criteria. Medical coverage criteria are available by calling Member Services, or log on to your “myHealthPartners” account at www.healthpartners.com.
19. Medical food. 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, except as required by Minnesota law. This exclusion does not apply to dietary treatment for Phenylketonuria (PKU), oral amino acid based elemental formula or other items if they meet our medical coverage criteria.
20. Charges for sales tax.
21. Genetic counseling and genetics studies, except when the results would influence a treatment or management of a condition or family planning decision. Our medical policies (medical coverage criteria) are available by calling Member Services, or log on to your “myHealthPartners” account at www.healthpartners.com.
22. Services provided by a family member of the enrollee, or a resident in the enrollee's home.
23. Religious counseling; marital/relationship counseling and sex therapy.
24. Private duty nursing services. This exclusion does not apply if the covered person is also covered under Medical Assistance under Minnesota chapter 256B to the extent that the services are covered under section 256B.0625, subdivision 7, with the exception of section 256B.0654, subdivision 4.
25. Services that are provided to a member, who also has other primary insurance coverage for those services and who does not provide us the necessary information to pursue Coordination of Benefits, as required under this Contract.
26. The portion of a billed charge for an otherwise covered service by a non-network provider, which is in excess of the usual and customary charges. We also do not cover charges or a portion of a charge which is either a duplicate charge for a service or charges for a duplicate service.
27. Charges for services (a) for which a charge would not have been made in the absence of insurance or health plan coverage, or (b) which the member is not obligated to pay, and (c) from providers who waive copayment, deductible and coinsurance payments by the member, except in cases of undue financial hardship.
28. Provider and/or member travel and lodging incidental to travel, regardless if it is recommended by a physician.
29. Health club memberships.
30. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
31. Autopsies.
32. Massage therapy for the purpose of comfort or convenience of the member.
33. For Network coverage, charges incurred for transplants, Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) received at facilities which are not designated facilities, or charges incurred for weight loss services provided by a physician who is not a designated physician.
34. Accident related dental services if treatment is (1) provided to teeth which are not sound and natural, (2) to teeth which have been restored, (3) initiated beyond six months from the date of the injury; (4) received beyond the initial treatment or restoration or (5) received beyond twenty-four months from the date of injury.
35. Nonprescription (over the counter) drugs or medications, unless listed on the formulary and prescribed by a physician or legally authorized health care provider under applicable state law, including, but not limited to, vitamins, supplements, homeopathic remedies, and non-FDA approved drugs. We cover off-label use of drugs to treat cancer as specified in the "Prescription Drug Services" section of the Benefits Chart. This exclusion does not include over-the-counter contraceptives for women as allowed under the Affordable Care Act when the member obtains a prescription for the item. In addition, if the member obtains a prescription, this exclusion does not include aspirin to prevent cardiovascular disease for men and women of certain ages; folic acid supplements for women who may become pregnant; fluoride chemoprevention supplements for children without fluoride in their water source; and iron supplements for children ages 6-12 who are at risk of anemia.
36. Charges for elective home births.
37. Professional services associated with substance abuse intervention. A “substance abuse intervention” is a gathering of family and/or friends to encourage a person covered under this contract to seek substance abuse treatment.
38. Services provided by naturopathic providers.
39. Oral surgery to remove wisdom teeth.
40. Acupuncture.
41. All drugs used for the treatment of sexual dysfunction.
42. All drugs used for the treatment of infertility.
43. Orthognathic treatment or procedures and all related services, unless it is required to treat TMD or CMD and it meets our medical coverage criteria.
44. Non-sedating oral antihistamines for which there are over-the-counter therapeutic alternatives.

45. Commercial weight loss programs and exercise programs and all weight loss/bariatric surgery.
46. Treatment, procedures, or services or drugs which are provided when you are not covered under this Contract.
47. Non-medical or non-dental administrative fees and charges included but not limited to medical or dental record preparation charges, appointment cancellation fees, after hours appointment charges, and interest charges.
48. Medical cannabis.

IV. DISPUTES AND COMPLAINTS

A. DETERMINATION OF COVERAGE

Eligible services are covered only when medically or dentally necessary for the proper treatment of a member. Our medical or dental directors, or their designees, make coverage determinations of medical or dental necessity, restrictions on access and appropriateness of treatment, and they 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. Frequency limits, deductibles, copayments or coinsurance, or other maximums or limits for certain covered pediatric dental services may not apply for certain medical conditions if you meet specific coverage criteria set by our dental directors. Covered prescription drugs are based on requirements established by the HealthPartners Pharmacy and Therapeutics Committee, and are subject to periodic review and modification.

B. COMPLAINTS

1. **In General:** We have a complaint procedure to resolve claims and disputes between or on behalf of members, applicants and us. Complaints should be made in writing or orally. They may be medical or dental or non-medical or non-dental in nature, or may concern the provision of care, administrative actions, or claims related to this Contract. Our member complaint system is limited to members, applicants, former members, or anyone acting on behalf of a member, applicant or former member seeking to resolve a dispute which arose during their membership or application for membership.

2. **Definitions:**

Complaint. This is any grievance by a complainant, as defined below, against us which has been submitted by a complainant and which is not under litigation. Examples of complaints are the scope of coverage for health care services; eligibility issues; denials, cancellations, or nonrenewals of coverage; administrative operations; and the quality, timeliness, and appropriateness of health care services provided. If the complaint is from an applicant, the complaint must relate to the application. If the complaint is from a former enrollee, the complaint must relate to services received during the time the individual was an enrollee.

Complainant. This is an enrollee, applicant, or former enrollee, or anyone acting on behalf of an enrollee, applicant or former enrollee, who submits a complaint.

3. **Complaint and Appeal Process**

- a. **Complaints:**

A complainant may submit a complaint to the Member Services Department either in writing or orally. A written complaint will be considered a first level appeal under the appeal process described in paragraph b. Member Services will make every effort to resolve the complaint. The Member Services Department will investigate the complaint and provide for informal discussions. If the oral complaint is not resolved to the complainant's satisfaction within 10 calendar days of receipt of the complaint, we will provide an appeal form to the complainant, which must be completed and returned to the Member Services Department for further consideration. We will offer to assist the complainant in completing this form. We will also offer to complete the form and mail it to the complainant for a signature.

If your claim for medical services was denied based on our clinical coverage criteria, you or your provider can discuss the decision with a clinician who reviewed the request for coverage. Call Member Services for assistance.

At any time, the complainant may also file a complaint with the Commissioner of Health regarding HealthPartners benefits, either in writing or by calling (651) 201-5100, or toll-free 1-800-657-3916 or the

b. Appeal Process:

A complainant can seek further review of a complaint not resolved through the complaint process described above. The steps in this appeal process are outlined below.

- 1. First Level Appeal.** You or your authorized representative must file your appeal within 180 days of the adverse determination. Send your written request for review, including comments, documents, records and other information relating to the appeal, the reasons you believe you are entitled to benefits, and any supporting documents to:

HealthPartners/HealthPartners Insurance Company
Member Services Department
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: (952) 883-5000 Outside the metro area: 1-800-883-2177

We will notify the complainant within 10 business days that we received the appeal, unless the appeal has been resolved to the complainant's satisfaction within those 10 business days.

Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your complaint, and you may also present evidence and testimony as part of the appeals process.

Concurrent Care Appeal. If you are appealing an ongoing course of treatment that has been previously approved by us, you will have continued coverage under the plan, pending the outcome of the appeal.

We will review your appeal and will notify you of our decision in accordance with the following timelines:

Appeals Involving Medical Necessity Determinations or Precertifications by CareCheck®.

If the appeal concerns urgent services, you and your health care provider may request an expedited review either orally or in writing. Within 72 hours of such request, a decision on your appeal will be made.

If the appeal concerns non-urgent services, a decision on your appeal will be made within 15 calendar days.

These time periods may be extended for up to 14 days if you agree. If we request an extension we will notify you in advance of the extension and the reasons for the extension.

All Other Appeals.

A decision on your appeal will be made within 30 calendar days. This time period may be extended for up to 14 days if you agree. If we request an extension we will notify you in advance of the extension and the reasons for the extension.

All notifications described above will comply with applicable law.

- 2. Second Level Appeal.** If you file a first level appeal (including pre-certification under CareCheck®) and it is denied, wholly or in part, you have the right to request external review of our decision without filing a second level appeal. See below for a description of this process. At your option, you or your authorized representative may, within 180 days of the denial, submit a written request

for a second level appeal, including any relevant documents, and submit issues, comments and additional information as appropriate to:

HealthPartners/HealthPartners Insurance Company
Member Services Department
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: (952) 883-5000 Outside the metro area: 1-800-883-2177

The Member Services Department will provide the complainant with the option of either a written reconsideration, or a hearing before the Member Appeals Committee either in person or over the phone. Hearings and written reconsiderations shall include the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, providers, or other persons, as is deemed necessary for a fair appraisal and resolution of the appeal. During your appeal, upon your request we will provide you, free of charge, reasonable access to all documents, records and other information relevant to your appeal.

We will review your appeal and written notice of the decision and all key findings will be given to the complainant within 30 calendar days of the Member Services Department's receipt of the complainant's written notice of appeal and request for written reconsideration.

These time periods may be extended if you agree.

3. External Complaint Procedures:

You must request external review within six months from the date of the adverse determination.

Expedited external appeal. You have a right to request an expedited external review if you receive:

- a. an adverse determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the enrollee or would jeopardize the enrollee's ability to regain maximum function and the enrollee has simultaneously requested an expedited internal appeal;
- b. an adverse determination that concerns an admission, availability of care, continued stay, or health care service for which the enrollee received emergency services but has not been discharged from a facility; or
- c. an adverse determination that involves a medical condition for which the standard external review time would seriously jeopardize the life or health of the enrollee or jeopardize the enrollee's ability to regain maximum function.

The external review entity must make its expedited determination to uphold or reverse the adverse determination as expeditiously as possible but within no more than 72 hours after the receipt of the request for expedited review and notify the enrollee and the health plan company of the determination.

If the external review entity's notification is not in writing, the external review entity must provide written confirmation of the determination within 48 hours of the notification.

Except as specified above, the following provision apply to external appeals:

- a. If your complaint is denied based on our medical necessity criteria, you have the right to request external review upon receiving notice of our decision on your complaint. If your complaint is denied for any other reason, you have the right to request external review upon notice of our decision at the completion of your first level appeal. However, if the complaint relates to a malpractice claim, the complaint shall not be subject to the Internal Complaint Process.
- b. To initiate the external review process, you may submit a written request for an external review to the Commissioner of Health (Commissioner of Commerce). This written request must be accompanied by a \$25 filing fee. This fee may be waived by the Commissioner in cases of financial hardship. We must participate in this external review, and must pay the cost of the review which exceeds the \$25 filing fee. If the adverse determination is completely reversed, the filing fee must be refunded. Filing fees are limited to \$75 in a contract year.
- c. Upon receipt of the request for external review, the external reviewer must provide immediate notice of the review to the complainant and to us. Within 10 business days, the enrollee and HealthPartners must provide the reviewer with any information they wish to be considered. The enrollee (who may be assisted or represented by a person of their choice) and HealthPartners shall be given an opportunity to present their versions of the facts and arguments. Any aspect of the external review involving medical determinations must be performed by a health care professional with expertise in the medical issue being reviewed.
- d. An external review must be made as soon as possible, but no later than 45 days after receipt of the request for external review. Prompt written notice of the decision and the reasons for it must be sent to the enrollee, the Commissioner of Health or Commissioner of Commerce, and to us.
- e. The results of the external review are non-binding on the enrollee and binding on us. We may seek judicial review on grounds that the decision was arbitrary and capricious or involved an abuse of discretion.

V. CONDITIONS

A. RIGHTS OF REIMBURSEMENT AND SUBROGATION

If we provide or pay for services to treat an injury or illness caused by the act or omission of another party and you receive full recovery from such party, we have the right to recover the value of those services and payments made. This right shall be by reimbursement and subrogation. We will be entitled to promptly collect the reasonable value of our subrogation rights from said settlement fund. Full recovery does not include payments made by the health plan to you or on your behalf. The right of subrogation means that we may make claim in your name or our name against any persons, organizations or insurers on account of such injury or illness.

This right of reimbursement and subrogation applies to any type of recovery from any third party, including but not limited to recoveries from tortfeasors, underinsured motorist coverage, uninsured motorist coverage, other substitute coverage or any other right of recovery, whether based on tort, contract, equity or any other theory of recovery.

If you make a claim against a collateral source for damages that include repayment for medical and medically related expenses covered under this Certificate, you are required to provide timely notice to us in writing. Our subrogation right will be reduced by a pro rata share of costs, disbursements, reasonable attorney fees and other expenses unless we are separately represented by an attorney. If we are separately represented by an attorney, we may enter into an agreement regarding allocation of costs. If an agreement cannot be reached regarding allocation, the matter shall be submitted to binding arbitration. Our rights under this part are subject to Minnesota Law. You should consult an attorney for information about the effect of Minnesota Law on our subrogation rights.

B. COORDINATION OF BENEFITS

You agree, as a member, to permit us to coordinate our obligations under this Contract with payments under any other health benefit plans as specified below, which cover you or your dependents. You also agree to provide any information or submit any claims to other health benefit plans necessary for this purpose. If you fail to provide this information, your claim may be delayed or denied. You agree to authorize our billing to other health plans, for purposes of coordination of benefits.

Unless applicable federal or state law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under this Contract must provide any facts needed to pay the claim.

1. Applicability.

- a. This coordination of benefits (COB) provision applies to this Contract when an enrollee or the enrollee's covered dependent has health care coverage under more than one plan. "Plan" and "This Plan" are defined below.
- b. If this coordination of benefits provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:
 - (1) shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but
 - (2) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in paragraph 4. below.

2. Definitions.

- a. **"Plan"** is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
 - (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

- b. **"This Plan"** is the part of this Contract that provides benefits for health care expenses.
- c. **"Primary Plan/Secondary Plan"** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more of the plans and may be a Secondary Plan as to a different plan or plans.

- d. **"Allowable Expense"** is a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

- e. **"Claim Determination Period"** is a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

3. Order Of Benefit Determination Rules.

- a. **General.** When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of another plan, unless:
 - (1) the other plan has rules coordinating its benefits with those of This Plan; and
 - (2) both those rules and This Plan's rules, in subparagraph b. below, require that This Plan's benefits be determined before those of the other plan.
- b. **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:
 - (1) Nondependent/Dependent. The benefits of the plan which cover the person as an enrollee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which cover the person as a dependent.
 - (2) Dependent Child/Parents not Separated or Divorced. Except as stated in subparagraph b., (3.) below, when This Plan and another plan cover the same child as a dependent of different persons, called "parents":
 - (a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
 - (b) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described in "(a.)" immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
 - (3) Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - (a) first, the plan of the parent with custody of the child;
 - (b) then, the plan of the spouse of the parent with the custody of the child; and
 - (c) finally, the plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.
 - (4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for health care expenses of the child, the plans covering follow the order of benefit determination rules outlined in subparagraph b., 2.
 - (5) Active/Inactive Enrollee. The benefits of a plan which covers a person as an enrollee who is neither laid off nor retired (or as that enrollee's dependent) are determined before those of a plan which cover that person as a laid off or retired enrollee (or as that enrollee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
 - (6) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an enrollee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

4. Effect On The Benefits Of This Plan.

- a. **When This Section Applies.** This paragraph 4. applies when, in accordance with paragraph 3. "Order of Benefit Determination Rules", This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B. immediately below.
- b. **Reduction in This Plan's Benefits.** The benefits of This Plan will be reduced when the sum of:

- (1) the benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
- (2) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

5. **Right To Receive And Release Needed Information.** Certain facts are needed to apply these COB rules. 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 federal or state law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under This Plan must give us any facts we need to pay the claim.
6. **Facility Of Payment.** A payment made under another plan may include an amount which should have been paid under This Plan. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.
7. **Right Of Recovery.** If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of:
 - a. the persons it has paid or for whom it has paid;
 - b. insurance companies; or
 - c. other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

The benefits provided by this plan do not apply to injury or disease covered by no-fault insurance, employers liability laws (including workers' compensation), and care available or required to be furnished by or through national or state governments or their agencies including care to which a member is legally entitled and for which facilities are reasonably available for military service-connected conditions or disabilities. Subject to our rights in part A. "Rights of Reimbursement and Subrogation" above, we will provide medically necessary services upon request and only pay expenses incurred for medical treatment otherwise covered by this plan if the no-fault insurer, employer, or national or state government or its agencies refuse to pay said expenses. You must cooperate with our program to bill allowable no-fault and workers' compensation claims to the appropriate insurer(s).

C. MEDICARE AND THIS CONTRACT

The provisions in this section apply to some, but not all, members who are eligible for Medicare. They apply in situations where the federal Secondary Medicare Payer Program allows Medicare to be the primary payer of a member's health care claims. Consult your Employer to determine whether or not Medicare is primary in your situation.

Medicare is the primary payer for members with end stage renal disease, after the 30 month period following the earlier of (1) the month in which the member begins a regular course of renal dialysis, or (2) the first of the month in which the member became entitled to Medicare, if the member received a kidney transplant without first beginning dialysis. This is regardless of the size of the employer. Medicare is primary payer for retirees who are age 65 or over. Also, Medicare is a primary payer for members under age 65, who are covered by Medicare because of disability (other than end stage renal disease), when: (1) the group health plan sponsor of This Plan employs fewer than 100 employees and the member or their spouse or parent has group health plan coverage due to current employment, or (2) the member or their spouse or parent has coverage not due to current employment, regardless of the number of employees of the employer.

Medicare is secondary payer for Medicare enrollees who: (1) are active employees and (2) are covered by Medicare because they have reached age 65 when there are 20 or more employees in the group. The Medicare secondary payer rules change from time to time and the most recent rule will be applied.

The benefits under this Contract are not intended to duplicate any benefits to which members are, or would be, entitled under Medicare. All sums payable under Medicare for services provided pursuant to this Contract shall be payable to and retained by us. Each member shall complete and submit to us such consents, releases, assignments and other documents as may be requested by us in order to obtain or assure reimbursement under Medicare for which members are eligible.

We also reserve the right to reduce benefits for any medical expenses covered under this Contract by the amount of any benefits available for such expenses under Medicare. This will be done before the benefits under this Contract are calculated. Charges for services used to satisfy a member's Medicare Part B deductible will be applied under this Contract in the order received by us. Two or more charges for services received at the same time will be applied starting with the largest first.

The benefits under this Contract are considered secondary to those under Medicare only when the member has actually enrolled in Medicare.

The provisions of this section will apply to the maximum extent permitted by federal or state law. We will not reduce the benefits due any member due to that member's eligibility for Medicare where federal law requires that we determine our benefits for that member without regard to the benefits available under Medicare.

VI. EFFECTIVE DATE AND ELIGIBILITY

A. EFFECTIVE DATE

Your coverage begins on the effective date contained in the information which accompanies your initial identification card. Your coverage is contingent upon fulfillment of the eligibility rules contained in the Master Group Contract.

An employee must be actively at work on the initial effective date of coverage or coverage for the employee and dependents will be delayed until the date the employee returns to work. The effective date of coverage shall not be delayed if the employee is not actively at work on the effective date of coverage due to the employee's health status, medical condition, or disability.

B. ELIGIBILITY

You must make written application to enroll yourself and any eligible dependents, and such application must be received by us within 31 days of the date you first become eligible, in order for coverage under this Contract to be effective on the eligibility date, except as specified below for newborn and newly adopted children. Similarly, you must make written application to enroll a newly acquired dependent, and we must receive such written application and receive any required payments, if any, within 31 days of when you first acquire the dependent (e.g., through marriage), in order for coverage under this Contract to be effective on the eligibility date.

Late Enrollment. If you do not enroll yourself or any eligible dependents within 31 days of the date that you or your dependents first become eligible, you may enroll yourself and any eligible dependents during the annual open enrollment period, or a special enrollment period.

Special Enrollment Period.

1. If you are eligible, but not enrolled for coverage under this Contract, or your dependent, if the dependent is eligible but not enrolled for coverage under this Contract, you or your dependent may enroll for coverage under the terms of this Contract if all of the following conditions are met:
 - a. you or your dependent were covered under a group health plan or had health insurance coverage at the time coverage was previously offered to you or your dependent;
 - b. you stated in writing at the time of initial eligibility that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the group health plan sponsor required this and provided you with notice of this requirement and the consequences of it;
 - c. you or your dependent's coverage described in a. above was:
 - (1) under a COBRA continuation provision and that coverage was exhausted; or
 - (2) not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation; divorce, death; termination of employment; cessation of dependent status; or reduction in the number of hours of employment; a situation in which the individual incurs a claim that would meet or exceed a lifetime limit on all benefits; a situation in which coverage is no longer offered to the class of similarly situated individuals that includes the individual; a situation in which an individual loses coverage through a health maintenance organization or other arrangement because that individual no longer resides, lives or works in the health maintenance organization's service area or a situation in which the individual's benefit option is terminated) or the employer contributions toward coverage were terminated; and
 - d. you requested this enrollment not later than 30 days after the date of exhaustion of coverage described in c. (1) above, one of the events listed in c. (2) above.
2. Dependents may enroll if: (a) a group health plan makes coverage available with respect to your dependent; (b) you are covered under the Contract (or have met any waiting period applicable to becoming covered under the Contract and are eligible to be enrolled under the Contract but for a failure to enroll during a previous enrollment period); and (c) a person becomes your dependent through marriage, birth, or adoption or placement for adoption. This Contract shall provide for a dependent special enrollment period during which the person may be enrolled under this Contract as your dependent and in the case of the birth or adoption of a child, your spouse may be enrolled as your dependent if otherwise eligible for coverage. You may also enroll at this time. A dependent special enrollment period shall be a period of not less than 30 days and shall begin on the later of:
 - a. the date dependent coverage is made available; or
 - b. the date of the marriage, birth, or adoption or placement for adoption described in (c) in the paragraph above.

If a member seeks to enroll a dependent during the first 30 days of a dependent special enrollment period, the coverage of the dependent shall become effective:

 - a. in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
 - b. in the case of a dependent's birth, as of the date of birth; or
 - c. in the case of a dependent's adoption or placement for adoption, the date of adoption or placement for adoption, or
 - d. in the case of a child support order or other court order, as of the date specified in the order.
3. You may also enroll yourself and any eligible dependents if you enroll within 30 days of any of the events under this item 3.:
 - a. If you or your dependents lose group coverage because of termination of employment (except for gross misconduct) or reduction in hours.
 - b. If you or your dependents lose group coverage because of the death of the enrollee.
 - c. If you or your dependents lose group coverage because of divorce or legal separation.
 - d. If your dependent loses group coverage because of loss of eligibility as a dependent child.
 - e. If you or your dependents lose group coverage because the group enrollee's initial enrollment for Medicare.
 - f. For a retired enrollee, spouse and other dependents, if you lose group coverage because of the bankruptcy filing by a former employer, under Title XI, United States Code, on or after July 1, 1986.

Special Rules Relating to Medicaid and the Children's Health Insurance Program ("CHIP"). In general, if you are eligible but not enrolled for coverage under the terms of this plan (or if your dependent is eligible but not enrolled for coverage under such terms), you may enroll for coverage under the terms of this plan if either of the following conditions is met:

- a. **Termination of Medicaid or CHIP Coverage.** You or your dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a state child health plan under title XXI of such Act and coverage of you or your dependent under such plan is terminated as a result of loss of eligibility for such coverage and you request coverage under this plan not later than 60 days after the date you or your dependent lose coverage under that plan; or
- b. **Eligibility for Employment Assistance under Medicaid or CHIP.** You or your dependent becomes eligible for assistance, with respect to coverage under this plan, under such Medicaid plan or state child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if you request coverage under this plan not later than 60 days after the date you or your dependent becomes eligible for such assistance.

Enrollment of Newborn or Newly Adopted Children. Newborn infants (including a newborn grandchild of a covered grandparent) and a newly adopted child, may be covered, regardless of when notice is received by us. However, you must make required payments, if any, from the date of eligibility for a newborn infant (including a newborn grandchild of a covered grandparent) and a newly adopted child. If you do not make the required payments, we may reduce the eligible benefits for the applicable dependent by the amount due.

C. CHANGES IN COVERAGE

Any change in coverage is subject to our approval. If a change in coverage is requested by us or the group health plan sponsor, it is effective on the date mutually agreed to by the group health plan sponsor and us, unless the provision pertaining to that change specifically provides otherwise. Any change in coverage made by us or the group health plan sponsor requires 31-day advance written notice.

Any change in coverage required by state or federal law becomes effective according to law.

VII. CONTINUATION OF GROUP COVERAGE

If your eligibility for group coverage under this Contract ends because of one of the events shown below, called "qualifying events," you may be eligible to continue group coverage. Each of these options is shown below.

A. CONTINUATION OF GROUP COVERAGE

1. **Qualifying Events.** Coverage under this Contract may be continued by an enrollee, spouse and other dependents, enrolled at the time coverage would otherwise end, or child born to or placed for adoption with the enrollee during the period of continuation coverage, as a result of one of the following qualifying events.
 - a. Termination of employment (except for gross misconduct) of the enrollee, or reduction in hours resulting in a loss of group coverage.
 - b. Death of the enrollee.
 - c. Divorce or legal separation from the enrollee.
 - d. Loss of eligibility as a dependent child.
 - e. Initial enrollment of the enrollee for Medicare.
 - f. For a retired enrollee, spouse and other dependents, the bankruptcy filing by a former employer, under Title XI, United States Code, on or after July 1, 1986.
2. **Duration of Continuation Coverage.** The maximum period coverage can be continued depends on the qualifying event. It may be terminated earlier as shown below. The maximum period of continuation coverage starts on the day of the qualifying event.
 - a. **Maximum period.**
 - (1) Termination and reduced hours. The maximum period of continuation coverage is 18 months. If a second qualifying event, other than the employer's bankruptcy, occurs during the 18 months, the maximum period of continuation coverage is 36 months. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".
 - (2) Disabled enrollee, spouse or dependent child. If the enrollee, spouse or other dependent is disabled under Title II or XVI of the Social Security Act, at any time during the first 60 days of continuation coverage, the 18-month maximum continuation period may be extended to 29 months. The disabled person must notify the group health plan sponsor within 60 days of the date

of determination of disability, and within the initial 18-month continuation period. If a second qualifying event (other than bankruptcy) occurs during the extended 29-month period, the maximum period of continuation coverage is 36 months. See part B. "Disabled Enrollee" below, which describes your rights for coverage as a disabled enrollee under Minnesota law.

- (3) Bankruptcy. In the case of bankruptcy of a retired enrollee's former employer, the maximum period of continuation coverage is until the death of the retired enrollee. In the case of the surviving spouse or dependent children of the retired enrollee, the maximum period of continuation coverage is 36 months after the death of the retired enrollee.
 - (4) Divorce or legal separation. Under Minnesota law, there is no maximum period of coverage for a former spouse or dependents who lose coverage due to divorce or legal separation. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".
 - (5) Death of enrollee. Under Minnesota law, there is no maximum period of coverage for a surviving spouse and dependents who lose coverage due to the death of the enrollee. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".
 - (6) Other qualifying events. The maximum period of continuation coverage for all other qualifying events is 36 months.
- b. **Earlier Termination.** Coverage terminates before the end of the maximum period if any of the following occurs.
- (1) End of the plan. The group health plan sponsor terminates the agreement under which this coverage is offered to its enrollees.
 - (2) Failure to pay premium. The person receiving continuation coverage does not make the monthly payment within 30 days of the due date.
 - (3) Other group health coverage. The person receiving continuation coverage becomes covered under any other group health type coverage, not containing an exclusion or limitation for any pre-existing condition of the person. If the other group health coverage contains a pre-existing condition limitation, continuation coverage is extended until the pre-existing limitation is satisfied or coverage is otherwise terminated. A person will not be subject to earlier termination of continuation coverage on account of coverage under another group plan that existed prior to that person's first day of continuation coverage.
 - (4) Termination of extended coverage for disability. In case a person receives extended (29-month) continuation coverage due to disability at the time of termination or reduced hours, the extended coverage terminates at the beginning of the month 30 days after a final determination that the person is no longer disabled. See part B. "Disabled Enrollee" below, which describes your rights for coverage as a disabled enrollee under Minnesota law.
 - (5) Termination provisions of this Contract. The person receiving continuation coverage is subject to the termination clause under section IX. of this Contract.

3. Election of Continuation Coverage.

- a. You have 60 days to elect continuation of group coverage. The 60-day period begins on the date your group coverage would otherwise terminate due to a qualifying event or the date on which written notice of your right of continued group coverage is received, whichever is later.
- b. If you wish to continue group coverage as shown above, you must apply in writing to your group health plan sponsor (not us). You must also pay your first monthly payment within 45 days of the date you elected to continue group coverage. If your coverage was terminated because of the death of the enrollee, your initial payment is not due until 90 days after you receive notice of the continuation right. Thereafter, your monthly payments are due and payable at the beginning of each month for which coverage is to be continued.
- c. You or your enrolled dependents must notify the group health plan sponsor within 60 days, when divorce, legal separation, change in status resulting in a loss of eligibility as a dependent would end coverage or a second qualifying event occurs. The 60-day period begins on the date of the divorce, legal separation, change in dependent status or second qualifying event.
- d. You may be required to pay the entire cost of COBRA continuation coverage plus a 2% administrative fee for each enrollee and enrolled dependent.

4. Procedures for Providing Notices Required Under This “Continuation of Group Coverage”.

- a. You must comply with the time limits for providing notices required in paragraph 3. above.
- b. Your notice must be in writing and contain at least the following information:
 - (1) The names of the enrollee, covered spouse and other covered dependents;
 - (2) The qualifying event or disability; and
 - (3) The date on which the qualifying event (if any) occurred.
- c. You must check with your employer for information regarding the person or entity that your notice should be sent to.

We will comply with applicable federal law for a member that is called to active military duty in the uniformed services.

B. DISABLED ENROLLEE

Pursuant to the provisions of Minnesota Statute 62A.148, the group health plan sponsor and we agree not to terminate, suspend or otherwise restrict the participation in, or the receipt of, benefits otherwise payable hereunder, to any enrollee who becomes totally disabled while employed by the group health plan sponsor and covered hereunder while this Contract is in force, solely due to absence caused by such total disability. The group health plan sponsor may require the enrollee to pay all or some part of the payment for coverage in this instance. Such payment shall be made to the group health plan sponsor by that enrollee.

For the purpose of this section the term "total disability" means (a) the inability of an injured or ill enrollee to engage in or perform the duties of the enrollee's regular occupation or employment within the first two years of such disability and (b) after the first two years of such disability, the inability of the enrollee to engage in any paid employment or work for which the enrollee may, by education or training, including rehabilitative training, be or reasonably become qualified.

C. REPLACEMENT OF COVERAGE AND CONFINED MEMBERS

When the group health plan sponsor replaces the Master Contract with that of another health plan offering similar benefits, coverage will be extended for a member who is confined in an institution or institutions for medical care or treatment that would otherwise be covered under this Contract. Coverage will be extended only for services related to the condition for which the confinement is required. Coverage for these services will end on the earlier of the date of discharge or the date benefits provided under the Contract are exhausted.

D. PUBLIC EMPLOYEES

Certain retired employees of public or governmental entities and their dependents may be eligible for continued coverage upon retirement, pursuant to Minnesota Statute 471.61. If you qualify under this law, you may be required to pay the entire premium for continued coverage and will be required to notify your employer within certain deadlines, of your intent to continue coverage.

VIII. TERMINATION

A member's coverage under this Contract terminates, when any of the following events occur.

1. The enrollment payment is due on or before the beginning of the month during which coverage is provided. There is a 31-day grace period during which to pay the required payment. Coverage under this Contract will continue in effect during the grace period. If no payment is received by us within the 31-day grace period, we will send the enrollee a notice of termination, stating that coverage will terminate 30 days from the date of notice for the enrollee and dependent. Coverage terminates, retroactive to the paid through date, but not more than 60 days prior to the end of the notice period. We are not obligated to accept any payment after the end of the grace period.
2. You are expected to pay all copayments and deductibles. If you do not make full payment, coverage under this Contract may terminate on the date following 30 days' advance notice by us.
3. When an enrollee ceases to be eligible under the terms of the Master Group Contract, coverage for the enrollee and all enrolled dependents terminates on the last day of the month in which the enrollee's eligibility ceases, unless group continuation is elected as described in section VII. A. above.

4. When an enrolled dependent no longer meets this Contract's definition of eligible dependent, coverage for that dependent terminates on the last day of the month in which the dependent's eligibility ceases, unless group continuation is elected as described in section VII. A. above.
5. When the maximum period under the group continuation coverage described in section VII. A. above expires for an enrollee or dependent.
6. When the Master Group Contract is terminated, either as requested by us or the health plan sponsor, in accordance with the terms of the Master Group Contract.
7. In the event of misstatements made by the applicant in the application for coverage under this plan, no misstatement, except fraudulent misstatements, shall be used to void this Contract or deny a claim for benefits covered under this Contract for loss incurred or disability commencing after the expiration of the two year period beginning from the issue date of this Contract.

If an enrollee or enrollee's dependent no longer meets the group health plan sponsor's eligibility requirements, or if the group health plan sponsor has forwarded enrollment for an enrollee or enrollee's dependent to us, regardless of whether such enrollee or enrollee's dependent meets their eligibility requirements, we are required to obtain the enrollee or enrollee's dependent's signature before we may retroactively terminate coverage under this Contract. If a required signature is not obtained, the group health plan sponsor is required to pay the premium for an enrollee or enrollee's dependent up to the date of termination. A signature is not required for retroactive termination for any other reason, including, but not limited to, voluntary or involuntary termination of employment or because the enrollee or enrollee's dependent committed fraud or misrepresentation with respect to eligibility or any other material fact.

To the extent that a termination would be considered a rescission under federal law under items 2, 3 and 4 above, the group health plan sponsor is required to give the member 30 days advance notice of termination.

IX. CLAIMS PROVISIONS

1. **Notice of Claims.** When a claim arises for services you have already received, you should notify us of the charges incurred in writing. This written notice of claim must be given within 20 days after any charges incurred, which are covered by this section, or as soon as reasonably possible. **Notice given to us by you or on behalf of you, at HealthPartners' claims office at 8170 33rd Avenue South, P.O. Box 1289, Minneapolis, MN 55440-1289, with information sufficient to identify you and the service, is deemed notice.**
2. **Claim Forms.** After receiving notice of claim, we will furnish you a claim form for filing your proof of loss. If you don't receive this within 15 days after notice is given to us, you should submit written proof which documents the date and type of service, provider name and itemized charges, for which a claim is made.
3. **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. Any bills for covered services must be submitted to the plan 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.
4. **Time of Payment of Claims.** 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. This time period may be extended by us for an additional 15 days for circumstances beyond our control.
5. **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.

6. **Physical Examinations and Autopsy.** This provision applies to Non-Network Benefits. In the event we require information from a physical examination or autopsy to properly resolve a claim dispute, we may request this information from you or your legal representative. Such examinations or autopsy shall be performed at our expense. Failure to submit the required information may result in denial of your claim.
7. **Information.** When you seek coverage for goods or services under this Plan, you grant us the right to collect and review any claims, eligibility, coordination of benefits, rights of subrogation or medical or dental information necessary to make a proper determination of coverage under this Plan. In the event you fail to cooperate with or execute any documents necessary for our review, we reserve the right to refuse to grant coverage for claims for which we have incomplete documentation.

X. STATEMENT OF ERISA RIGHTS

For group health plans that are subject to ERISA, federal law and regulations require that this "Statement of ERISA Rights" be included in this Group Membership Contract. This "Statement of ERISA Rights" is not applicable to group health plans that are not subject to ERISA. Your group health plan sponsor can tell you whether or not your plan is subject to ERISA. ERISA rights are in addition to any rights you may also have under state law; however, federal law may not invalidate, impair or supersede state law.

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and where applicable, copies of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and, where applicable, copies of the latest annual report (Form 5500) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights. See Section VIII of this Group Membership Contract.

Prudent actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of non-privileged documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that the plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance With Your Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

XI. SPECIFIC INFORMATION ABOUT THE PLAN

The federal government requires that the following information be furnished for the Plan:

Name of the Plan:	See your employer's plan documents.
Address of the Plan:	See your employer's plan documents.
IRS Employer Identification Number:	See your employer's plan documents.
Plan Identification Number:	See your employer's plan documents.
Plan Year:	See your employer's plan documents.
Plan Fiscal Year Ends:	See your employer's plan documents.
Plan Administrator:	Your employer.
Agent for Service of Legal Process:	For this Group Membership Contract's benefits: HealthPartners For all other matters: your employer.
Named Fiduciary:	For this Group Membership Contract's benefits: HealthPartners For all other matters: your employer.
Funding:	This Group Membership Contract is fully insured under Minnesota law.
Network Providers:	HealthPartners and APN Providers Network
Contributions:	Employer and Employee. For more details, see your employer's enrollment materials.
Employment Waiting Period:	See your employer's plan documents.
Eligible Classes:	See your employer's plan documents.
Contact for Continuation of Coverage Notices:	See your employer's plan documents.

