CLAIMS PAYMENT POLICIES & OTHER INFORMATION

A. OUT OF NETWORK LIABILITY AND BALANCE BILLING

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

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

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

B. ENROLLEE CLAIMS SUBMISSION

All providers are responsible for submitting claims to HealthPartners on behalf of the member. If a member seeks services from a Non-Contracted provider and that provider has not submitted the claim on behalf of the member, the member can mail the claim or itemized statement, with information sufficient to identify themselves and the service provided, to:

HealthPartners Insurance Company
8170 33rd Avenue South, P.O. Box 1289
Minneapolis, MN 55440-1289

For questions please contact us at: 952-883-5000

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.

Claim Forms. After receiving notice of claim, we will furnish a claim form for filing proof of loss. If this form is not received within 15 days after notice is given, you should submit written proof which documents the date and type of service, provider name and itemized charges, for which a claim is made.

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

HealthPartners within 15 months of incurring the charges. Any bill received after 15 months from the date of service can be denied even if it is for a covered service, unless you were unable to submit the bill because you were legally incompetent.

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

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

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

Information. When you seek coverage for goods or services under this Policy, you grant us the right to collect and review any claims, eligibility, coordination of benefits, or medical or dental information necessary to make a proper determination of coverage under this Policy. In the event you fail to cooperate with or execute any documents necessary for our review of coverage requests, or coordination of benefits, or rights of subrogation, we reserve the right to refuse to grant coverage without receipt of necessary information.

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

Time Limit on Certain Defenses. After two years from the effective date of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the enrollment form for this Policy, shall be used to void the Policy or to deny a claim for loss incurred, commencing after the expiration of such two-year period. No claim for loss incurred commencing after two years from the effective date of this Policy is reduced or denied on the ground that a disease or physical condition not excluded from benefits by name or specific description effective on the date of loss has existed prior to the effective date of coverage under this Policy.

C. GRACE PERIODS AND CLAIMS PENDING POLICIES

Coverage under this Policy is conditioned on our regular receipt of the enrollee's premium payments. Premium payments are based upon the policy type and the number and status of any dependents enrolled with the enrollee. Premium payments do not take into account the claim experience or any change in health status of the enrollee, which occurs after the initial issuance of this Policy. Your premium payments usually change annually on your Renewal Date (which may be different than your effective date), subject to 60 days' notice. The Renewal Date of the Policy may be subject to change.

HealthPartners will default your premium payments to a pre-payment, mailed paper statement, on a monthly cycle.

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

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

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

D. RETROACTIVE DENIALS

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

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

E. ENROLLEE RECOUPMENT OF OVERPAYMENT

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

If there is a credit or overpayment on a canceled policy, the credit will be refunded to the policy holder within 4 weeks.

F. MEDICAL NECESSITY AND PRIOR AUTHORIZATION

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 maximum coverage available to you under this Policy. You can designate another person to contact CareCheck® for you.

CARECHECK® Services. CareCheck® is HealthPartners Insurance Company's utilization review program. CareCheck® must precertify inpatient confinement and same day surgery, and new, experimental or

reconstructive outpatient technologies or procedures, and durable medical equipment or prosthetics costing over $3,000, and home health services after your visits exceed 30, and skilled nursing facility stays, and diagnostic imaging (CT, MRI, PET, Nuclear Cardiology).

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 inpatient confinement or surgery is scheduled, but not less than 48 hours 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.

Failure to Comply With CareCheck® Requirements. If you fail to make a request for precertification of services in the time noted above, but your inpatient confinement or outpatient surgery is subsequently approved as medically necessary, we will reduce the eligible charges by 20%.

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 Policy.

Information Needed When You Call CareCheck®

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

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

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 calendar 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 that you have not provided all information necessary to make a decision, you will be notified of such failure within 24 hours. You will then be given 48 hours to provide the requested information. 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 you to provide the specified additional information.

How to contact CareCheck®. You may call **952-883-6400** or **1-800-942-4872** 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.

G. FORMULARY EXCEPTION PROCESS

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

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

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

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

H. INFORMATION ON EXPLANATION OF BENEFITS (EOBS)

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

I. COORDINATION OF BENEFITS

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

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

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

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

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