



HealthPartners®

HealthPartners Insurance Company

Group Certificate

*HealthPartners Insurance Company Minnesota
Small Employer Plan*



Statement of Nondiscrimination for Health Plan Members

Our Responsibilities:

We follow Federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex. We do not exclude people or treat them differently because of their race, color, national origin, age, disability or sex, including gender identity.

- We help people with disabilities to communicate with us. This help is free. It includes:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio and accessible electronic formats
- We provide services for people who do not speak English or who are not comfortable speaking English. These services are free. They include:
 - Qualified interpreters
 - Information written in other languages

For Language or Communication Help:

Call 1-800-883-2177 if you need language or other communication help. (TTY: 711)

If you have questions about our non-discrimination policy:

Contact the Civil Rights Coordinator at 1-844-363-8732 or integrityandcompliance@healthpartners.com.

To File a Grievance:

If you believe that we have not provided these services or have discriminated against you because of your race, color, national origin, age, disability or sex, you can file a grievance by contacting the Civil Rights Coordinator at 1-844-363-8732, integrityandcompliance@healthpartners.com or Civil Rights Coordinator, Office of Integrity and Compliance, MS 21103K, 8170 33rd Ave. S., Bloomington, MN 55425.

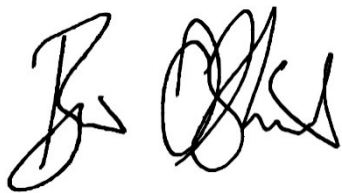
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
Room 509F, HHH Building
200 Independence Avenue SW, Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

<p>Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-883-2177. (TTY: 711)</p>	<p>ພາສາລາວ (Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການລ່ວມເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-883-2177. (TTY: 711)</p>
<p>Hmoob (Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-883-2177. (TTY: 711)</p>	<p>Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-883-2177. (TTY: 711)</p>
<p>Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-883-2177. (TTY: 711)</p>	<p>العربية (Arabic) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-883-2177 (رقم هاتف الصم والبكم: 711)</p>
<p>繁體中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-883-2177. (TTY: 711)</p>	<p>Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-883-2177. (ATS: 711)</p>
<p>Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-883-2177. (телетайп: 711)</p>	<p>한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-883-2177. (TTY: 711)</p>
<p>Af Soomaali (Somali) OGAYSIIIS: Haddii aad ku hadasho afka soomaaliga, Waxaa kuu diyaar ah caawimaad xagga luqadda ah oo bilaash ah. Fadlan soo wac 1-800-883-2177. (TTY: 711)</p>	<p>Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-883-2177. (TTY: 711)</p>

<p>Oromiffa (<i>Cushite [Oromo]</i>) XIYEEFFANNA: Afaan dubbattu Oromiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-883-2177. (TTY: 711)</p>	<p>Italiano (<i>Italian</i>) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-883-2177. (TTY: 711)</p>
<p>አማርኛ (<i>Amharic</i>) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች በነጻ ሊያገዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-883-2177. (መስማት ለተሳናቸው፡ 711)</p>	<p>ภาษาไทย (<i>Thai</i>) เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-883-2177. (TTY: 711)</p>
<p>unD (<i>Karen</i>) ဟ်သုာ်ဟ်သး- နမ့ၢ်ကတိၤ ကညိၣ် ကျိာ်အသိၣ်, နမ့ၢ်ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘျုးလၢာ်စ့ၤ နိတမံၤဘၣ်သ့ၣ်န့ၣ်လီၤ. ကိး 1-800-883-2177. (TTY: 711)</p>	<p>ελληνικά (<i>Greek</i>) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-883-2177. (TTY: 711)</p>
<p>ខ្មែរ (<i>Mon-Khmer, Cambodian</i>) ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-800-883-2177. (TTY: 711)</p>	<p>Diné Bizaad (<i>Navajo</i>) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiił'eh, éí ná hóló, kójj' hódíilnih 1-800-883-2177. (TTY: 711)</p>
<p>Deutsch (<i>Pennsylvanian Dutch</i>) Wann du Deutsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-883-2177. (TTY: 711)</p>	<p>Ikirundi (<i>Bantu – Kirundi</i>) ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-883-2177. (TTY: 711)</p>
<p>Polski (<i>Polish</i>) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-883-2177. (TTY: 711)</p>	<p>Kiswahili (<i>Swahili</i>) KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-883-2177. (TTY: 711)</p>
<p>हिंदी (<i>Hindi</i>) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-883-2177. (TTY: 711)</p>	<p>日本語 (<i>Japanese</i>) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-883-2177 (TTY: 711) まで、お電話にてご連絡ください。</p>
<p>Shqip (<i>Albanian</i>) KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-883-2177. (TTY: 711)</p>	<p>नेपाली (<i>Nepali</i>) ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-883-2177 (टिटिवाइ: 711)</p>
<p>Srpsko-hrvatski (<i>Serbo-Croatian</i>) OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-883-2177. (TTY: 711)</p>	<p>Norsk (<i>Norwegian</i>) MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-883-2177. (TTY: 711)</p>
<p>ગુજરાતી (<i>Gujarati</i>) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-883-2177. (TTY: 711)</p>	<p>Adamawa (<i>Fulfulde, Sudanic</i>) MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-883-2177. (TTY: 711)</p>
<p>اُردُو (<i>Urdu</i>) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-800-883-2177 (TTY: 711)</p>	<p>Українська (<i>Ukrainian</i>) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-883-2177. (телетайп: 711)</p>

HealthPartners Insurance Company



Brian O'Shields
President



Nancy L. Evert
Secretary

Group Insurance Certificate Medical Expense Benefits

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BENEFITS CHART

MISSION

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

ABOUT HEALTHPARTNERS INSURANCE COMPANY AND HEALTHPARTNERS

HealthPartners Insurance Company. HealthPartners Insurance Company is the insurance company underwriting the benefits described in this Certificate. HealthPartners Insurance Company is a part of the HealthPartners family of related organizations. When used in this Certificate, “we”, “us” or “our” has the same meaning as “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 administers the benefits described in this Certificate. HealthPartners is the parent company of a family of related organizations and provides administrative services for HealthPartners Insurance Company.

The coverage described in this Certificate and the Benefits Chart may not cover all your health care expenses. Read this Certificate carefully to determine which expenses are covered.

IMPORTANT CONSUMER INFORMATION

- You have the right to a grace period of 31 days for each enrollment payment due, when falling due after the first enrollment payment, during which period the plan shall continue in force.
- Insureds on Medicare have the right to voluntarily disenroll from HealthPartners Insurance Company and the right not to be requested or encouraged to disenroll, except in circumstances specified in federal law.
- Insureds on Medicare have the right to a clear description of nursing home and home care benefits covered by HealthPartners Insurance Company.
- Certain services or medical or dental supplies are not covered. Read this Certificate for a detailed explanation of all exclusions.
- You may continue coverage under certain circumstances. Read this Certificate for a description of your continuation rights.
- Your coverage may be cancelled by you or us only under certain conditions. Read this Certificate for the reasons for cancellation of coverage.

TERMS AND CONDITIONS OF USE OF THIS CERTIFICATE

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

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

INTRODUCTION TO THE GROUP CERTIFICATE

GROUP CERTIFICATE

This Group Certificate (this Certificate) is the enrollee's evidence of coverage, under the Group Policy issued by HealthPartners Insurance Company to the enrollee's group health plan sponsor. The Group Policy provides for the medical and dental coverage described in this Certificate. It covers the enrollee and the enrolled dependents (if any) as named on the enrollee's application. This Certificate replaces all certificates previously issued by us.

Under this Certificate, 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.

IDENTIFICATION CARD

An identification card will be issued to you at the time of enrollment. You will be asked to present your identification card whenever you receive services. You may not permit anyone else to use your card to obtain care.

ASSIGNMENT OF BENEFITS

You may not in any way assign or transfer your rights or benefits under this Certificate. In addition, you may not, in any way assign or transfer your right to pursue any causes of action arising under the Plan including, but not limited to, causes of action for denial of benefits under the Plan.

ENROLLMENT PAYMENTS

This Certificate 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 certificate 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.

BENEFITS

This Certificate provides **Network Benefits** underwritten by HealthPartners Insurance Company, when you seek medical and dental services delivered by participating network providers.

This Certificate describes your Network Benefits and how to obtain covered services.

This Certificate 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 Certificate describes your Non-Network Benefits and how to obtain covered services.

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. Prior authorization is not required from CareCheck® for services by Network providers. See "CareCheck®" in this Certificate 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. The limits are described following the benefit levels for these services.

Second Opinions. If you question a decision about medical or dental care, we cover a second opinion from another provider.

If you are insured under this Certificate you may have access to certain additional benefits and discounts offered by or through an arrangement with HealthPartners from time to time.

BENEFITS CHART

Attached to this Certificate is a Benefits Chart, which is incorporated and fully made a part of this Certificate. It describes the amounts of payments and limits for the coverage provided under this Certificate. Refer to your Benefits Chart for the amount of coverage applicable to a particular benefit.

AMENDMENTS TO THIS CERTIFICATE

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

GROUP POLICY

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

CONFLICT WITH EXISTING LAW

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

HOW TO USE THE NETWORK

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

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

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 us to provide health care services to you.

To see what physicians and other health care providers are in your network, log onto your "myHealthPartners" account at healthpartners.com. If you need assistance locating a physician or other health care providers in your network, please contact Member Services.

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 network providers. There are limited exceptions as described in this Certificate.

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

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 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 Network benefit for up to 120 days under this Certificate if you qualify for continuity of care benefits.

Conditions that qualify for this benefit are:

- an acute condition;
- a life-threatening mental or physical illness;
- pregnancy beyond the first trimester of pregnancy;
- 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
- 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. Continuity of care may continue for the rest of the enrollee's life if a physician, advanced practice registered nurse, or physician assistant certifies that the enrollee has an expected lifetime of 180 days or less.

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

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 healthpartners.com for a list of which services require your physician to obtain prior authorization.

You do not need a referral or prior approval from a primary care physician to see providers who specialize in obstetrics and gynecology as specified in Minnesota statute 62Q.52.

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 our Member Services Department or log on to your "myHealthPartners" account at healthpartners.com for a list of which services require 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 HealthPartners Benefits.

Our medical or dental directors, or their designees, make coverage determinations of medical and dental necessity and make final authorization for certain 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 service is required, we will make an initial determination within 10 calendar 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 at the time of the review.

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 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 our receipt of the complete information or the end of the time granted to you to provide the specified additional information.

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 under “Disputes and Complaints” for a description of how to proceed.

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

Scheduled telephone care 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 Computed 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 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 or verify 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 Network Benefits. Coverage is described in the Benefits Chart.

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

DISCLOSURE OF PAYMENTS FOR HEALTH CARE SERVICES

If you request information on the allowable payment that a provider has agreed to accept from us for services specified by you, we shall, at no cost to you, provide a good faith estimate of the amount within 10 business days of your request.

STEP THERAPY OVERRIDE PROCESS

If we require that you follow a step therapy protocol to get coverage of a specific drug, you may request to override this process if certain conditions apply. You can get more information on our step therapy protocols and requesting a step therapy override by calling Member Services or logging on to your “myHealthPartners” account at healthpartners.com.

If a step therapy override request is denied by us, you or your prescribing health care provider, if designated by you, may appeal by using the complaint procedure under “Disputes and Complaints.”

We shall respond to a step therapy override request or an appeal within five days of receipt of a complete request. In cases where exigent circumstances exist, we shall respond within 72 hours of receipt of a complete request.

If we do not respond within this timeline, the override request of appeal is granted and binding on us.

UNAUTHORIZED PROVIDER SERVICES

1. Except as provided in paragraph 3, unauthorized provider services occur when you receive services:
 - a. From a non-network provider at a network hospital or ambulatory surgical center, when the services are rendered:
 - (1.) Due to unavailability of a network provider;
 - (2.) By a non-network provider without your knowledge; or
 - (3.) Due to the need for unforeseen services arising at the time services are being rendered; or
 - b. From a network provider that sends your specimen from the network provider's practice setting to a non-network laboratory, pathologist, or other medical testing facility.
2. Unauthorized provider services do not include emergency services as defined in Minnesota Statute 62Q.55, subdivision 3.
3. The services described in paragraph 1, clause (b) are not unauthorized provider services if you give advance written consent to the provider acknowledging that the use of a provider, or the services to be rendered, may result in costs not covered by the health plan.

Your financial responsibility for unauthorized provider services shall be the same cost-sharing requirements, including copayments, deductibles, coinsurance, coverage restrictions, and coverage limitations, as those applicable to services received from a network provider. A health plan company must apply your cost sharing amounts, including copayments, deductibles, and coinsurance, for non-network provider services to your annual out-of-pocket limit to the same extent payments to a participating provider would be applied.

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

CARECHECK® Services. CareCheck® is HealthPartners Insurance Company's 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.

Procedure to Follow to Receive Maximum Benefits

- **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.
- **For medical non-emergencies.** A phone call must be made to CareCheck® when services requiring precertification are scheduled, but not less than two 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.

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%.

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 Certificate.

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 group number;
- the patient's name, birth date, the relationship to the enrollee and the patient's group 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.

Pre-certification Process

When a pre-certification for a non-urgent service is requested from HealthPartners, an initial determination must be made within 10 business days.

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.

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 a pre-certification and want to request an appeal, you have the right to do so. If your complaint is not resolved to your satisfaction, you may request an external review under certain circumstances. Refer to the information regarding Appeals Involving Medical Necessity Determinations or Precertifications by CareCheck® in "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.

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: 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 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.

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.

Authorized Representative. This is a person appointed by you to act on your behalf in connection with an initial claim, an appeal of an adverse benefit determination, or both. To designate an authorized representative, you must complete and sign our "Appointment of Authorized Representative" form and return it to us. You should specify on the form the extent of the authorized representative's authority. This form is available by logging on to your "myHealthPartners" account at healthpartners.com.

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, as covered in the Non-Network Benefits of this Certificate.

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

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 the Benefits Chart.

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. Your 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 Certificate, 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 Certificate may qualify for continuation of coverage within the group as provided in this Certificate.

1. **Spouse.** This is an enrollee's current legal spouse. If both married spouses are covered as enrollees under this Certificate, 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.)

3. **Qualified Grandchild.** This is a covered grandchild of an enrollee or an enrollee's spouse who resides with and is financially dependent on the covered grandparent. The grandchild must be either under 26 years of age or a disabled dependent, as described below.
4. **Disabled Child.** This Certificate covers disabled children. A disabled child is a child who is and continues to be both (a) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability and (b) chiefly dependent upon the employee for support and maintenance, provided proof of such incapacity and dependency is furnished to us by the employee within 31 days of the child's attainment of the limiting age and subsequently as may be required by us, but not more frequently than annually after the two-year period following the child's attainment of the limiting age. Any notice regarding termination of coverage due to attainment of the limiting age will notify you of this right.
5. **Disabled Dependent.** This Certificate covers disabled dependents. A disabled dependent is a person who is and continues to be both: (a) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and (b) chiefly dependent upon you for support and maintenance. Disabled dependents are not subject to any pre-existing condition limitations, or insurability, eligibility, or health underwriting approval.

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 Group Policy, applies and is accepted by us for coverage under this Certificate.

Enrollment Date. This is the first day of coverage under this Certificate, 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 Certificate'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 motor development. To be considered habilitative, measurable functional improvement and measurable progress must be made toward achieving functional goals, within a predictable period of time toward an insured's maximum potential ability.

Health Care Provider (Provider). This is any licensed non-physician (excluding naturopathic providers), including a podiatrist, optometrist or chiropractor, lawfully performing a medical or dental service within the scope of his or her license and in accordance with applicable governmental licensing privileges and limitations, who renders direct patient care as covered in this Certificate.

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.

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

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

Inpatient. This is a medically necessary confinement for acute care of illness or injury, other than in a hospital's outpatient department, where a charge for room and board is made by the hospital or skilled nursing facility. We cover a semi-private room, unless a physician recommends that a private room is medically necessary. In the event you choose to receive care in a private room under circumstances in which it is not medically necessary, our payment toward the cost of the room shall be based on the average semi-private room rate in that facility.

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

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

- There is final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the United States Food and Drug Administration (FDA); and
- The drug or device or medical, behavioral health or dental treatment or procedure is not the subject of ongoing Phase I, II or III clinical trials; and
- The drug, device or medical, behavioral health or dental treatment or procedure is not under study and further studies are not needed (such as post-marketing clinical trial requirements) to determine maximum tolerated dose, toxicity, safety, effect on health outcomes or efficacy as compared to existing standard means of treatment or diagnosis; and
- There is conclusive evidence in major peer-reviewed medical journals demonstrating the safety, effectiveness and positive effect on health outcomes (the beneficial effects outweigh any harmful effects) of the service or treatment when compared to standard established service or treatment. Each article must be of well-designed investigations, using generally acceptable scientific standards that have been produced by nonaffiliated, authoritative sources with measurable results. Case reports do not satisfy this criterion. This also includes consideration of whether a drug is included in one of the standard reference compendia or “Major Peer Reviewed Medical Literature” (defined below) for use in the determination of a medically necessary accepted indication of drugs and biologicals used off-label as appropriate for its proposed use.

Major Peer Reviewed Medical Literature. This means articles from major peer reviewed medical journals that have recognized the drug or combination of drugs' safety and effectiveness for treatment of the indication for which it has been prescribed. Each article shall meet the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or be published in a journal specified by the United States Secretary of Health and Human Services pursuant to United States Code, title 42, section 1395x, paragraph (t), clause (2), item (B), as amended, as acceptable peer review medical literature. Each article must use generally acceptable scientific standards and must not use case reports to satisfy this criterion.

Maintenance Care. This is supportive services, including skilled or non-skilled nursing care, to assist you when your condition has not improved or has deteriorated significantly over a measurable period of time (generally a period of two months). Care may be determined to be maintenance care, regardless of whether your condition requires skilled medical care or the use of medical equipment.

Medically Necessary Care.

1. With respect to services other than mental health services:

This is diagnostic testing and medical treatment and prescription drug use which is medically appropriate to your physical diagnosis for an injury or illness, and preventive services covered in this Certificate. Medically necessary care must meet the following criteria:

- it meets clinically accepted medical services and practice parameters of the general medical community; and

- it meets the most appropriate and cost-effective level of medical services, prescription drugs or supplies that can be safely provided. When applied to inpatient care, it further means that the medical symptoms or conditions require that the medical services or supplies cannot be safely provided in a lower level of care setting; and
- it restores or maintains health; or
- it prevents deterioration of your condition; or
- it prevents the reasonably likely onset of a health problem or detects an incipient problem.

To be considered medically necessary care, it must not be maintenance or custodial care, or ineffective care, or otherwise excluded under this Certificate. The fact that an authorized network, or non-network, provider prescribes treatment does not necessarily mean the treatment is covered under this Certificate.

2. With respect to mental health services:

This is health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

- help restore or maintain your health; or
- prevent deterioration of your condition.

The fact that an authorized network, or non-network, provider prescribes treatment does not necessarily mean the treatment is covered under this Certificate.

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.

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, as covered in this Certificate. 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).

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, as covered in this Certificate.

Prescription Drug. This is any medical substance for prevention, diagnosis or treatment of injury, disease or illness approved and/or regulated by the Federal Food and Drug Administration (FDA). It must (1) bear the legend: "Caution: Federal Law prohibits dispensing without a prescription" or "Rx Only"; and (2) be dispensed only by authorized prescription of any physician or legally authorized health care provider under applicable state law. Drugs that are newly approved by the FDA must be reviewed by HealthPartners Pharmacy and Therapeutics Committee. This process may take up to six months after market availability.

Reconstructive Surgery. This is limited to reconstructive surgery, incidental to or following surgery, resulting from injury, illness or other disease of the involved part, or to correct a covered dependent child's congenital disease or anomaly which has resulted in a functional defect 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.

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

Skilled Nursing Facility. This is a licensed skilled nursing facility, lawfully performing medical services in accordance with governmental licensing privileges and limitations, and which is recognized as an appropriate facility by us, to render inpatient post-acute hospital and rehabilitative care and services to you when your condition requires skilled nursing facility care. It does not include facilities which provide treatment of mental or chemical health.

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

SERVICES NOT COVERED

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

1. Treatment, procedures or services or drugs which are not medically or dentally necessary and/or which are primarily educational in nature or for your vocation, comfort, convenience, appearance, or recreation, including skills training.
2. Procedures, technologies, treatments, facilities, equipment, drugs and devices which are considered investigative, or otherwise not clinically accepted medical or dental 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 except as specified elsewhere in this Certificate, non-human organ implants and/or transplants not specifically listed in this Certificate. While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered.
3. Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders, including Applied Behavior Analysis (ABA), Intensive Early Intervention Behavior Therapy (IEIBT), and Lovaas.
4. Rest and respite services and custodial care, except as respite services are specifically described in the Benefits Chart under the subsection "Home Hospice Services". This includes all services, medical equipment and drugs provided for such care.
5. Halfway houses, extended care facilities, including shelter services, correctional services, detention services, transitional services, group homes, foster care services and wilderness programs.
6. Foster care, adult foster care and any type of family child care provided or arranged by the local state or county.
7. Services associated with non-covered services, including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies. This exclusion does not apply to medically necessary complications related to an excluded service if they would otherwise be covered under this Certificate.
8. 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.
9. Cosmetic surgery, cosmetic services and treatments, including drugs, primarily for the improvement of your appearance or self-esteem, including, but not limited to, augmentation procedures, reduction procedures and scar revision. This exclusion does not apply to services for port wine stain removal and reconstructive surgery.
10. Dental treatment, procedures or services not listed in the Benefits Chart.
11. 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.

12. 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. This exclusion does not apply to chemical dependency treatment for which coverage is required by Minnesota Statute 62Q.137.
13. Court ordered treatment, except as described in the Benefits Chart under the subsections “Mental Health Services” and “Office Visits for Illness or Injury” or as otherwise required by law.
14. Treatment of infertility, including but not limited to, office visits, laboratory and diagnostic imaging services and drugs for the treatment of infertility; 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; reversal of sterilization; artificial insemination; and sperm, ova or embryo acquisition, retrieval or storage; however, we do cover office visits and consultations to diagnose infertility.
15. Services related to the establishment of surrogate pregnancy and fees for a surrogate. However, pregnancy and maternity services are covered for an insured under this Certificate including a surrogate pregnancy.
16. Routine foot care, unless the services meet our criteria for medically necessary care.
17. Vision correction surgeries such as keratotomy and keratorefractive surgeries, including LASIK surgery, except as specifically described in the medical coverage criteria.
18. Eyeglasses, contact lenses and their fitting, measurement and adjustment, except as specifically described in the Benefits Chart. This exclusion does not apply to pediatric eyewear.
19. Communication aids or devices: equipment to create, replace or augment communication abilities including, but not limited to, speech processors, receivers, communication boards, or computer or electronic assisted communication.
20. Hearing aids (implantable and external, including osseointegrated or bone anchored) and their fitting, except as specifically described in this Certificate. This exclusion does not apply to cochlear implants.
21. 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 special dietary treatment for Phenylketonuria (PKU) if it is recommended by a physician or oral amino acid based elemental formula or other items if they meet HealthPartners medical coverage criteria.
22. 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 logging on to your “myHealthPartners” account at healthpartners.com.
23. Services provided by a family member of the enrollee, or a resident in the enrollee's home.
24. Religious counseling; marital/relationship counseling and sex therapy.
25. Private duty nursing services, except for training for ventilator-dependent persons as described in the Inpatient Hospital Services section of the Benefits Chart. This exclusion does not apply to Home Care Services if the insured 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.
26. Services that are paid by other primary insurance coverage.
27. For Non-Network Benefits, the portion of a billed charge for an otherwise covered service by a 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.
28. 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 you are not obligated to pay.
29. Provider and/or insured travel and lodging incidental to travel, regardless if it is recommended by a physician except as specified in the Transplant Travel Benefit section of the Benefits Chart.
30. Health club memberships.
31. Massage therapy for the purpose of comfort or convenience of the insured.
32. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
33. Autopsies, unless we request an autopsy to resolve a claim dispute.

34. Your plan does not provide Network Benefits for: services received from Non-Network providers; charges for transplants received at non-designated facilities; charges for Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) received at non-designated facilities; charges for weight loss services provided by non-designated providers.
35. 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.
36. Nonprescription (over the counter) drugs or medications, including, but not limited to, vitamins, supplements, homeopathic remedies and non-FDA approved drugs, unless listed on the formulary drug list and prescribed by a physician or legally authorized health care provider under applicable state and federal law.
37. Charges for sales tax.
38. Charges for elective home births.
39. Professional services associated with substance abuse interventions. A “substance abuse intervention” is a gathering of family and/or friends to encourage a person covered under this certificate to seek substance abuse treatment.
40. Services provided by naturopathic providers.
41. Oral surgery to remove wisdom teeth, except as covered for an individual to the end of the month in which they turn 19 as specified in the pediatric dental amendment.
42. Acupuncture.
43. All drugs used for sexual dysfunction.
44. Orthognathic treatment or procedures and all related services, unless it is required to treat TMD, CMD, cleft lip and cleft palate, and it meets our medical coverage criteria.
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 Certificate.
47. Non-medical or non-dental administrative fees and charges including but not limited to medical or dental record preparation charges, appointment cancellation fees, after hours appointment charges, and interest charges.
48. Medical cannabis.
49. Drugs on the Excluded Drug List. The Excluded Drug List includes select drugs within a therapy class that are not eligible for coverage. This includes drugs that may be excluded for certain indications. You can find our Excluded Drug List if you go to healthpartners.com, select Pharmacy and select any of our formularies. This exclusion does not apply to formulary exceptions for anti-psychotic drugs. See definition of Formulary in the Benefits Chart.
50. Drugs that are newly approved by the FDA until they are reviewed and approved by HealthPartners Pharmacy and Therapeutics Committee.
51. Hair prostheses (wigs), except as specifically described in the Benefits Chart.
52. Charges for phone, data, software or mobile applications/apps unless specifically described as covered in our medical coverage criteria for the device or service.

DISPUTES AND COMPLAINTS

DETERMINATION OF COVERAGE

Eligible services are covered only when medically or dentally necessary for the proper treatment of an insured. 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.

COMPLAINTS

1. **In General:** We have a complaint procedure to resolve claims and disputes between or on behalf of insureds, 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 Certificate. Our insured complaint system is limited to insureds, applicants, former insureds, or anyone acting on behalf of an insured, applicant or former insured seeking to resolve a dispute which arose during their coverage or application for coverage.

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. The Member Services Department 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 business 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 Commerce, either in writing to MN Department of Commerce, Consumer Protection, 85 7th Place East, Suite 280, Saint Paul, MN 55101 or by calling (651) 539-1500 or toll-free 1-800-657-3602.

- b. **Appeals 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 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 appeal and you may also present evidence and testimony as part of the appeals process.

Concurrent Care Appeal. If you are appealing a reduction or termination of an ongoing course of treatment that has been previously approved by us, you will have continued coverage under the plan, pending the final outcome of the appeal, including subsequent levels of appeal. This does not apply to requests for an extension to the already approved period of treatment or number of visits.

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 relating to a health care service or claim (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. If your request was denied after the first level appeal of any other issue, and does not involve a determination of medical necessity or precertification, 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 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 telephone. 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.

4. External Complaint Procedures:

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

You have the right to proceed to external review without exhausting the internal complaint or appeal process under the following circumstances:

- we waive the exhaustion requirement;
- we are considered to have waived the exhaustion requirement by failing to substantially comply with any requirements including but not limited to, time limits for internal complaints or appeals; or
- you apply for an expedited external review at the same time as you qualify and apply for an expedited internal review.

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

- 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;
- 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
- 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 provisions apply to external appeals:

- 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 our internal appeal process.
- To initiate the external review process, you may submit a written request for an external review to the Commissioner of Commerce. This written request must be accompanied by a \$25 filing fee payable to the Minnesota Department of Commerce. 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 policy year.

- 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 Insurance Company 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 Insurance Company 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.
- 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 Commerce, and to us.
- 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.

CONDITIONS

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.

COORDINATION OF BENEFITS

You agree to permit us to coordinate our obligations under this Certificate 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 Certificate must provide any facts needed to pay the claim.

1. Applicability.

- a. This coordination of benefits (COB) provision applies to this Certificate 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 Certificate 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 Certificate 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 an insured 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, insured 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, insured 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 shall not duplicate coverage for 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 you are legally entitled and for which facilities are reasonably available for military service-connected conditions or disabilities. We may send you a letter asking you to confirm in writing or by calling us whether there is third party liability, employer liability or whether you have access to coverage under a governmental entity or agency. We will provide medically necessary services and 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 or if benefits under such coverage are exhausted. You must cooperate with our program to bill allowable no-fault and worker's compensation claims to the appropriate insurer(s).

MEDICARE AND THIS CERTIFICATE

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

Medicare is the primary payer for persons with end stage renal disease, after the 30 month period following the earlier of (1) the month in which the insured begins a regular course of renal dialysis, or (2) the first of the month in which the insured became entitled to Medicare, if the insured 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 insureds under age 65, who are covered by Medicare because of disability (other than end stage renal disease), when (1) the employer employs fewer than 100 employees and the insured or their spouse or parent has group health plan coverage due to current employment, or (2) the insured 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 Certificate are not intended to duplicate any benefits to which insureds are, or would be, entitled under Medicare. All sums payable under Medicare for services provided pursuant to this Certificate shall be payable to and retained by us. Each insured 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 insureds are eligible.

We also reserve the right to reduce benefits for any medical expenses covered under this Certificate by the amount of any benefits available for such expenses under Medicare. This will be done before the benefits under this Certificate are calculated. Charges for services used to satisfy an insured's Medicare Part B deductible will be applied under this Certificate 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 Certificate are considered secondary to those under Medicare only when the insured 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 insured where federal law requires that we determine our benefits for that insured without regard to the benefits available under Medicare.

EFFECTIVE DATE AND ELIGIBILITY

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 Group Policy.

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.

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 Certificate 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 premium payments, if any, within 31 days of when you first acquire the dependent (e.g., through marriage), in order for coverage under this Certificate 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 Certificate, or your dependent, if the dependent is eligible but not enrolled for coverage under this Certificate, you or your dependent may enroll for coverage under the terms of this Certificate 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, or 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 this Certificate (or have met any waiting period applicable to becoming covered under this Certificate and are eligible to be enrolled under this Certificate 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 Certificate shall provide for a dependent special enrollment period during which the person may be enrolled under this Certificate 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 an insured 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;
- 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.

Enrollment of Newborn or Newly Adopted Children. Newborn infants (including a newborn grandchild of a covered grandparent) are covered immediately from the moment of birth regardless of when notice is received by us. Newly adopted children are covered on the date of placement, 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.

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:

- 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
- 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.

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.

No change in this Certificate shall be valid until approved by an executive officer of HealthPartners Insurance Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Certificate or to waive any of its provisions.

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

CONTINUATION OF GROUP COVERAGE

If your eligibility for group coverage under this Certificate ends because of one of the events shown below, called “qualifying events,” you may be eligible to continue group coverage.

CONTINUATION OF GROUP COVERAGE

- 1. Qualifying Events.** Coverage under this Certificate may be continued by an enrollee, spouse and other dependents, enrolled at the time coverage would otherwise end, or a 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. Voluntary or involuntary termination of employment (except for gross misconduct) of the enrollee, or layoff from employment, or reduction in hours resulting in a loss of group coverage.
 - b. Death of the enrollee.
 - c. Divorce or legal separation from the enrollee. A former spouse is only eligible for continuation if the spouse was covered under this plan the day before the entry of a valid decree of dissolution of marriage.
 - d. Loss of eligibility as a dependent child.
 - e. Initial enrollment of the enrollee for benefits under Title XVIII of the Social Security Act (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.) Initial enrollment of the enrollee for benefits under Title XVIII of the Social Security Act (Medicare). If a spouse or dependent children lose coverage under this plan when the enrollee initially enrolls for benefits under Title XVIII of the Social Security Act, they may continue coverage under this plan for a maximum period of 36 months.
 - (7.) 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 Certificate. The person receiving continuation coverage whose coverage is subject to the termination clause under the "Termination" section of this Certificate.

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 mailed, 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. If you are a former spouse of the enrollee and the enrollee is enrolled for coverage that would cover a current spouse, your coverage is continued at no additional premium, until the enrollee cancels such coverage. If the enrollee cancels dependent coverage for their current spouse, you will then be required to pay continuation premium as described in the first sentence of this paragraph.

4. Procedures for Providing Notices Required under this “Continuation of Group Coverage” section.

- a. You must comply with the time limits for providing notices required in paragraph 3.c. 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 covered employee that is called to active military duty in the uniformed services.

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 Certificate 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.

REPLACEMENT OF COVERAGE WHEN YOU ARE CONFINED

When the group health plan sponsor replaces the Group Policy with that of another health plan offering similar benefits, coverage will be extended if you are confined in an institution for medical care or treatment that would otherwise be covered under this Certificate. Coverage will be extended only for services related to the confinement and incurred prior to the date that coverage ends or services billed with the facility charges. Coverage for these services will end on the earlier of the date of discharge or the date benefits provided under this Certificate are exhausted.

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.

TERMINATION

An insured's coverage under this Certificate terminates, when any of the following events occur.

1. The premium 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 Certificate 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. When an enrollee ceases to be eligible under the terms of the Group Policy, 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 "Continuation of Group Coverage" above.
3. When an enrolled dependent no longer meets this Certificate'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 "Continuation of Group Coverage" above.
4. When the Certificate maximum eligibility period under the group continuation coverage described in "Continuation of Group Coverage" above expires for an enrollee or dependent.
5. When the Group Policy is terminated, either as requested by us or the health plan sponsor, in accordance with the terms of the Group Policy.
6. When the group health plan sponsor terminates participation under the Group Policy.
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 Certificate or deny a claim for benefits covered under this Certificate for loss incurred or disability commencing after the expiration of the two year period beginning from the issue date of this Certificate.

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 Certificate. 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.

We make a good faith effort to notify all insureds of termination at least 30 days before the effective termination date, except if we have reasonable evidence to indicate that it will be replaced by a substantially similar policy, plan or contract. In no event shall this provision extend coverage more than 120 days beyond the date coverage would otherwise cancel, based on the terms shown above.

To the extent that a termination would be considered a rescission (a cancellation or discontinuance of coverage under a health plan that has a retroactive effect) under federal law under items 2, 3 and 4 above, the group health plan sponsor is required to give the insured 30 days advance notice of termination.

STANDARD PROVISIONS

- **Reinstatement:** If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring an application for reinstatement, the insured's policy shall be reinstated. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium paid, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application.

The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

- **Legal Actions:** No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.
- **Time Limit on Certain Defenses:** After two years from the date of issue of this Certificate no misstatements, except fraudulent misstatements, made by the insured in the application for coverage under this Certificate shall be used to void the coverage under this Certificate or to deny a claim for loss incurred or disability commencing after the expiration of such two year period.

CLAIMS PROVISIONS

Notice of Claims. If you receive services from a network provider, the provider will submit a claim to us for you. If you receive services from a non-network provider, you must submit a claim to us. You can get a claim form on our website at healthpartners.com or by calling Member Services. Send us your claim form with an itemized list of the services provided on the provider's stationery, including the following information:

- Identification of provider: full name, address, tax or license ID numbers, and provider numbers.
- Patient information: first and last name, date of birth, gender, relationship to plan member, and daytime phone number.
- Date(s) of service.
- Charge for each service.
- Place of service (office, hospital, etc.).
- For injury or illness: date and diagnosis.
- For inpatient claims: admission date, patient status, attending physician ID.
- Days or units of service.
- Revenue, diagnosis, and procedure codes.
- Description of each service.

Send any claims to:

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

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, 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 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.

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 Certificate. 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 supercede 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 Administration.

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 “Continuation of Group Coverage” in this Group Certificate.

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.

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 Certificate's benefits: HealthPartners Insurance Company For all other matters: your employer.
Named Fiduciary:	For this Group Certificate's benefits: HealthPartners Insurance Company For all other matters: your employer.
Funding:	This Group Certificate is fully insured under Minnesota law.
Network Providers:	HealthPartners 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.