



HealthPartners Insurance Company

Group Certificate

HealthPartners Insurance Company
Wisconsin Small Employer Plan

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE ENROLLMENT FORM FOR YOUR INSURANCE

Omissions or misstatements in the enrollment form could cause an otherwise valid claim to be denied. Carefully check the enrollment form and write to the insurer within 10 days if any information shown on the form is not correct and complete or if any requested medical history has not been included. The insurance coverage was issued on the basis that the answers to all questions and any other material information shown on the enrollment form are correct and complete.

For covered services delivered by a network provider, our payment is based on the negotiated provider fee for a given medical/surgical service, procedure or item.

For covered services delivered by non-network providers, a contracted rate may apply if such arrangement is available to HealthPartners.

For the usual and customary charge for covered services provided by a non-network provider, our payment is calculated using one of the following options to be determined at HealthPartners' discretion: 1) a percentage of the Medicare fee schedule; 2) a comparable schedule if the service is not on the Medicare fee schedule; or 3) a commercially reasonable rate for such service.

The usual and customary charge is the maximum amount allowed that we consider in the calculation of the payment of charges incurred for certain covered services. You must pay for any charges above the usual and customary charge, and they do not apply to the Out-of-Pocket Limit.

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

Please save for future reference.

MGC-900.21-WI-SE
(HSA-21)

**NOTICE: LIMITED BENEFITS WILL BE PAID WHEN
NON-PARTICIPATING PROVIDERS ARE USED.**

You should be aware that when you elect to utilize the services of a non-participating provider for a covered service, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the Policy. YOU RISK PAYING MORE THAN THE COINSURANCE, DEDUCTIBLE AND COPAYMENT AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill enrollees for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payment for covered services with no additional billing to the enrollee other than copayment, coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling (952) 883-7000 or 1-866-443-9352 number on your identification card or visiting HealthPartners' website at healthpartners.com.

HealthPartners Insurance Company

Certificate of Coverage

Your rights and benefits are governed by the provisions of the Group Policy. The Group Policy, along with this Certificate and any amendments, describes those rights and benefits. This Certificate is your evidence of coverage while you are insured under the Group Policy. This Certificate tells you what you must do to be covered and it explains how to file claims. This Certificate also explains what to do and who you can contact if you have a grievance or complaint.

Coverage under this Certificate begins on the effective date shown on the information that you get with your initial identification card.

PLEASE READ YOUR CERTIFICATE CAREFULLY.

This Certificate limits eligible expenses to the usual and customary charges for non-network services. The usual and customary charge may be less than the billed charge. You must pay the difference between the billed charge and the usual and customary charge. See the definition of "charge" in the Benefits Chart for a more detailed explanation.

You may contact HealthPartners Insurance Company's Member Services number printed on your identification card prior to having a procedure performed. Member Services can tell you what the eligible expense allowed will be, based on the usual and customary charge. Ask your provider for the Current Procedural Terminology (CPT) code and the estimated charge prior to calling Member Services.



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 (<i>Spanish</i>) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-883-2177. (TTY: 711)</p>	<p>ພາສາລາວ (<i>Laotian</i>) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການລູ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-883-2177. (TTY: 711)</p>
<p>Hmoob (<i>Hmong</i>) 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 (<i>German</i>) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-883-2177. (TTY: 711)</p>
<p>Tiếng Việt (<i>Vietnamese</i>) 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 (<i>Arabic</i>) 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 (<i>Chinese</i>) 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 (<i>French</i>) 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 (<i>Russian</i>) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-883-2177. (телетайп: 711)</p>	<p>한국어 (<i>Korean</i>) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-883-2177. (TTY: 711)</p>
<p>Af Soomaali (<i>Somali</i>) OGAYSIIS: 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 (<i>Tagalog</i>) 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 ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚኒተለው ቁጥር ይደውሉ 1-800-883-2177. (መስማት ለተሳናቸው: 711)</p>	<p>ภาษาไทย (<i>Thai</i>) เรียบน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-883-2177. (TTY: 711)</p>
<p>unD (<i>Karen</i>) ဟ်သုဂ်ဟ်သး- နမ့ကတိံ ကညိံ ကျိံအယိံ, နမန့ ကျိံအတိံမၤစၢလၢ တလၢကတိံလၢကတိံစၢ နိတမံဘၣ်သ့န့ၣ်လိံ. ကိံ: 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: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់បម្រើអ្នក។ 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 jiik'eh, éí ná hóló, kójj' hódííłnih 1-800-883-2177. (TTY: 711)</p>
<p>Deutsch (<i>Pennsylvanian Dutch</i>) Wann du Deutsch schwetzsch, 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 språkassistanstjenester tilgjengelige for deg. Ring 1-800-883-2177. (TTY: 711)</p>
<p>ગુજરાતી (<i>Gujarati</i>) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક 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>Ukranian</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>

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HEALTHPARTNERS 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 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 Certificate 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

The 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.

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 this Certificate including, but not limited to, causes of action for denial of benefits under this Certificate.

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 HealthPartners network providers.

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

This Certificate also provides 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.

Applicable to Non-Network Benefits

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.

CHANGES IN BENEFITS

We are permitted to change benefits under the Group Policy to maintain compliance with federal and state law. This includes, but is not limited to, benefit changes required to maintain a certain actuarial value or metal level. We may also change your deductible, copayment, and/or coinsurance and out-of-pocket limit values on an annual basis to reflect cost of living increases.

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.

ENTIRE CONTRACT

The entire contract between HealthPartners Insurance Company and the group health plan sponsor includes:

- The HealthPartners Insurance Company Group Policy;
- 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.

The 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 Wisconsin and governed by the laws thereof.

CONFLICT WITH EXISTING LAW

In the event that any provision of this Certificate is in conflict with Wisconsin 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.

Designated Physician, Provider or Facility. This is a current list of network physicians, providers or facilities which are authorized to provide certain covered services as described in this Certificate. Call Member Services, or log on to your "myHealthPartners" account at healthpartners.com for a current list.

Network Provider. This is any one of the participating licensed physicians, dentists, mental health and substance abuse treatment 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.

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 HEALTHPARTNERS NETWORK

To obtain Network Benefits for covered services, you must select and receive services from HealthPartners network providers. There are limited exceptions as described in this Certificate.

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

HealthPartners Network Clinic. This is a participating clinic providing ambulatory medical or dental services.

Continuity of Care. In the event your current primary care physician provider is no longer a part of the HealthPartners network, you may continue to receive services from the provider, for the period of time shown below, and such services may be considered a covered Network Benefit.

- Until the end of the current plan year if the material/information provided to you included a primary care physician provider who is not a part of the HealthPartners network; or
- If you are undergoing a course of treatment with a provider who is not a primary care physician, services will be continued until the shorter of (a) ninety (90) days after the provider's participation under the HealthPartners network ends, or (b) until the end of the course of treatment, or (c) until the end of the plan year; or
- If your course of treatment is maternity care, and you are beyond the first trimester of your pregnancy when the provider's participation under the HealthPartners network ends, services may be continued until the end of postnatal care for you and the newborn child.

Continuity of care benefits will not be available or may be discontinued if the provider no longer practices in the service area, or is terminated from HealthPartners network for misconduct.

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

Authorizations for Network Services

There is no referral requirement for services delivered by providers within your network. You must obtain authorization from us for certain services for the services to be covered as Network 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 Member Services or log on to your “myHealthPartners” account at healthpartners.com for a list of which services require prior authorization.

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 14 calendar days, so long as all information reasonably needed to make the decision has been provided. This time period may be extended for an additional 14 calendar days. 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 Complaint and Grievance Procedure in the section of this Certificate titled, “DISPUTES AND COMPLAINTS” for a description of how to proceed.

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

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

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 your Benefits Chart.

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.

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

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

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

ACCESS TO RECORDS AND CONFIDENTIALITY

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

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.

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 the “Continuation of Group Coverage” section of 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 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.)

The age 26 limit does not apply to a dependent child who was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces, prior to the age of 27, while the child was attending on a full-time basis an institution of higher education. For a dependent child who meets this requirement, coverage will continue for as long as the child is enrolled as a full-time student. A child who is not able to maintain full time student status due to a medically necessary leave of absence continues to be an eligible dependent provided the enrollee sends documentation from the student's treating physician that certifies the medical necessity of the leave. Coverage for a student who is on a medically necessary leave of absence will continue until the earlier of one year from the date that the leave occurs or coverage under this Policy otherwise terminates.

3. **Qualified Grandchild.** This is an unmarried child of a covered Child who is younger than age 18. The child must be either under age 18 years of age, or a disabled dependent as described below.
4. **Disabled Dependent.** This is an enrollee's Child or Qualified Grandchild as defined in 2. and 3. above, who is beyond the limiting age and physically handicapped or mentally disabled, and dependent on the enrollee for the majority of his/her financial support. The disability must have come into existence prior to attainment of the limiting age described above. Disability does not include pregnancy. "Disabled" means incapable of self-sustaining employment by reason of intellectual disability or physical handicap. The enrollee must give us a written request for coverage of a disabled dependent. The request must include written proof of disability and must be approved by us, in writing. We must receive the request within 31 days of the date an already enrolled dependent becomes eligible for coverage under this definition. We reserve the right to periodically review disability, provided that after the first two years, we will not review the disability more frequently than once every 12 months.

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

Enrollee. This is a person who is eligible through the group health plan sponsor's 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 Services. Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Care Provider (Provider). This is any licensed non-physician (excluding naturopathic providers), including 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 or Experimental. As determined by us, a drug, device, medical, behavioral health or dental treatment is investigative or experimental if reliable evidence does not permit conclusions concerning its safety, effectiveness, or positive effect on health outcomes and will be considered investigational or experimental 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. This is health care services and prescription drug use that are appropriate in terms of type, frequency, level, setting and duration to your diagnosis or condition, diagnostic testing and preventive services. Medically necessary care, as determined by us must be:

- Appropriate for the symptoms, diagnosis or treatment of your medical condition;
- Consistent with evidence-based standards of medical practice where applicable;
- Not primarily for your convenience or that of your family, your physician, or any other person; and
- 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, prescription drugs or supplies cannot be safely provided in a lower level of care setting.

The fact that a physician, participating provider, or any other provider, has prescribed, ordered, recommended or approved a treatment, service, prescription drug or supply, or has informed you of its availability, does not in itself make it medically necessary.

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 health or substance abuse treatment service in accordance with governmental licensing privileges and limitations, who renders mental health or substance abuse treatment 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.

Prescription drugs include drugs for the treatment of HIV infection if the drug is approved by the FDA for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection, including investigational or experimental drugs which are prescribed and administered in accordance with the treatment protocol approved for the investigative new drug.

Preventive Services. This includes routine health care, such as cancer screenings, check-ups, and patient counseling, preventive care, such as physicals, immunizations and screenings, like cancer screenings, designed to prevent or discover illness, disease, or other health problems as described in the Preventive Services section of the Benefits Chart.

Reconstructive Surgery. This is limited to reconstructive surgery, incidental to or following surgery, or resulting from injury or illness of the involved part. Coverage for newborn children includes functional repair and restoration of congenital defects and birth abnormalities. A functional defect is one that interferes with normal body functioning.

Rehabilitative Services. Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

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.

Totally Disabled. For an enrollee who is employed on a full-time or part-time basis, totally disabled means (a) the inability of an injured or ill enrollee to engage in or perform the duties of his or her occupation or employment within the first two years of such disability and (b) after the first two years of such disability, the inability to engage in any paid employment or work for which he or she may, by education or training, including rehabilitative training, be or reasonably become qualified. For other Insureds, totally disabled means the inability, due to illness or injury, to engage in all of the activities of a healthy person of the same age and gender.

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. For Network Benefits, treatment, procedures or services which are not provided by a HealthPartners network physician or other authorized network provider.
3. Procedures, technologies, treatments, facilities, equipment, drugs and devices which are considered investigative or experimental, or otherwise not clinically accepted medical or dental services. We consider the following transplants to be investigative or experimental and do not cover them: surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, non-human organ implants and/or transplants and other transplants not specifically listed in this Certificate.

While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered.
4. Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders that are not evidence based, including Applied Behavioral Analysis (ABA), Intensive Early Intervention Behavior Therapy (IEIBT), and Lovaas.
5. Rest and respite services and custodial care, except respite services as specified under the “Home Hospice Services” benefit. This includes all services, medical equipment and drugs provided for such care.
6. Halfway houses, extended care facilities or comparable facilities.
7. Foster care, adult foster care, and any type of family child care provided or arranged by the local, state or county.
8. Services associated with non-covered services, including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies. This exclusion does not apply to medically necessary complications related to an excluded service if they would otherwise be covered under this Certificate.
9. Services from non-medically or non-dentally licensed facilities or providers and services outside the scope of practice or license of the individual or facility providing the service.
10. Cosmetic surgery, cosmetic services and treatments, 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 reconstructive surgery.
11. Dental treatment, procedures or services not listed in the Benefits Chart.
12. Vocational rehabilitation and recreational or educational therapy. Recreational therapy is therapy provided solely for the purpose of recreation, including but not limited to: (a) requests for physical therapy or occupational therapy to improve athletic ability, and (b) braces or guards to prevent sports injuries.
13. Health services and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise medically necessary, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) competency evaluations, and adoption studies. However, if a court orders an examination or treatment for a mental health condition, those services will be covered as described in the Benefits Chart. Any resulting court ordered treatment for mental health services will be subject to this Certificate’s requirement for medical necessity.
14. Treatment of infertility, including but not limited to, office visits, laboratory, 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 cover office visits and consultations to diagnose infertility.
15. Services related to the establishment of surrogate pregnancy and fees for a surrogate are not covered. Pregnancy and maternity services are covered for an Insured under this Certificate.
16. Acupuncture.

17. Routine foot care unless the services meet criteria for medically necessary care.
18. Vision correction surgeries such as keratotomy and keratorefractive surgeries, including LASIK surgery, except as specifically described in the medical coverage criteria.
19. Eyeglasses, contact lenses and their fitting, measurement and adjustment, except as specifically described in the Benefits Chart.
20. Implantable and osseointegrated or bone-anchored hearing aids and their fitting, except as specifically described in the Benefits Chart. This exclusion does not apply to cochlear implants.
21. 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.
22. 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. This exclusion does not apply to oral amino acid based elemental formula or other items if they meet HealthPartners medical coverage criteria.
23. Drugs for the treatment of growth deficiency.
24. 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 on our website at healthpartners.com.
25. Services provided by a family member of the enrollee, or a resident in the enrollee's home.
26. Religious counseling; marital/relationship counseling and sex therapy.
27. Private duty nursing services.
28. Services that are provided to you, if you also have other primary insurance coverage for those services and you do not provide us the necessary information to pursue Coordination of Benefits, as required under this Certificate.
29. 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.
30. 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 legally obligated to pay, and (c) from providers who waive copayment, deductible and coinsurance payments by the Insured, except in cases of undue financial hardship.
31. 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.
32. Health club memberships.
33. Orthognathic treatment or procedures and all related services.
34. Massage therapy for the purpose of comfort or convenience of the Insured.
35. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
36. Autopsies.
37. For Network Benefits, charges incurred for transplants, Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) received at facilities which are not designated facilities.
38. 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.
39. Charges for, or in connection with, an injury or illness which arises out of, or in the course of, any employment (including self-employment) for wage or profit, or for which the individual is entitled to benefits under any Workers' Compensation Law, Occupational Disease Law, or similar legislation.
40. All drugs used for the treatment of sexual dysfunction.

41. 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 and prescribed by a physician or legally authorized health care provider under applicable state and federal law. The formulary is a current list, which may be revised from time to time, of prescription drugs, medications, equipment and supplies. The formulary is available by calling Member Services, or on our web site at healthpartners.com. This exclusion does not include over-the-counter contraceptives for women as allowed under the Affordable Care Act when the Insured obtains a prescription for the item. In addition, if the Insured obtains a prescription, this exclusion does not include aspirin to prevent cardiovascular disease for men and women of certain ages; folic acid supplements for women who may become pregnant; fluoride chemoprevention supplements for children without fluoride in their water source; and iron supplements for children ages 6-12 who are at risk for anemia.
42. Hair prostheses (wigs).
43. Charges for phone, data, software or mobile applications/apps unless specifically described as covered in our medical coverage criteria for the device or service.
44. Charges for sales tax.
45. Charges for elective home births.
46. 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.
47. Services provided by naturopathic providers.
48. Oral surgery to remove wisdom teeth.
49. Commercial weight loss programs and exercise programs, and all weight loss/bariatric surgery.
50. Treatment, procedures, or services or drugs which are provided when you are not covered under this Certificate.
51. 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.
52. Medical cannabis.
53. Drugs on the Excluded Drug List. The Excluded Drug List includes select drugs within a therapy class that are not eligible for coverage. This includes drugs that may be excluded for certain indications. The Excluded Drug List is available at healthpartners.com.
54. Drugs that are newly approved by the FDA until they are reviewed and approved by HealthPartners Pharmacy and Therapeutics Committee.

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 and make final authorization for certain covered services. Coverage determinations are based on established medical policies, which are subject to periodic review and modification by the medical or 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. 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.

COMPLAINTS

1. **In General.** We have a complaint procedure to resolve concerns you may have about benefits, administrative processes, or services from us or from our contracted providers. Most concerns can be resolved quickly and informally through the complaint process. You may issue your complaint by calling our Member Services Department. This complaint process is available to Insureds, applicants, former Insureds, or any authorized representative acting on behalf of an Insured, applicant or former Insured seeking to resolve a concern which arose during the Insured's membership or application for membership.

2. **Definitions**

Adverse Determination. This is a denial, reduction, or termination of, or failure to provide or make payment for a benefit for any of the following reasons:

- Failure to provide or make payment for a benefit based on a utilization review.
- Failure to provide or make payment for a benefit based on a determination that the benefit is investigational or experimental.

In addition, an adverse determination includes a recession of coverage. A recession is a discontinuance or cancellation of coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a recession if it is effective retroactively because of a failure to pay premiums or contributions on a timely basis.

Complaint. This is an expression of dissatisfaction by you or your authorized representative pertaining to services or benefits provided by us or our contracted providers during your enrollment or application for enrollment on this Plan.

Experimental Treatment Determination. A determination by, or on behalf of HealthPartners Insurance Company, to which all of the following apply:

- A proposed treatment has been reviewed;
- Based on the information provided, the treatment has been determined to be experimental according to the terms of this Plan;
- Based on the information provided, we have denied payment for the treatment.

Grievance. This is a written statement of dissatisfaction by a complainant pertaining to concerns about our provision of services, claims practices or benefit administration during the Insured's enrollment or application for enrollment on this Plan.

3. **Complaint and Grievance Procedure**

a. **Complaint Process**

If you have a concern and you would like our assistance, you may call our Member Services department at 1-866-443-9352 to issue a complaint. Our Member Services department will investigate the complaint, provide for informal discussions and notify the complainant of the outcome of our review. We will make every effort to resolve the complaint.

If you are dissatisfied with our resolution, you may pursue the plan's grievance process. You may alternately skip this complaint process and proceed directly to the grievance process.

If your complaint involves a claim for medical services that 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. He or she should refer to the denial notice for information or call our Member Services department for assistance.

b. **Grievance Process**

You or your authorized representative may seek further review of a complaint not resolved through the complaint process described above. The steps in this grievance process are outlined below.

- (1) **Standard Grievance.** You or your authorized representative must file your written request (appeal) for review, within 3 years of the adverse decision. Send your written request for review including comments, documents, records and other information relating to the grievance, the reasons you believe you are entitled to benefits, and any other supporting information to:

HealthPartners Insurance Company
Member Services Department
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: (952) 883-7000 1-866-443-9352

Within 5 business days of receiving your appeal, we will deliver or deposit in the mail to you or your authorized representative a written notification stating we received the appeal.

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 grievance.

You or your authorized representative have the right to appear in person before, or by teleconference with, the grievance committee to present any verbal testimony, written comments, records, or documents pertinent to the grievance. We will send you written notification of the date, time, and place of the grievance panel meeting at least seven (7) days prior to the meeting date.

We will review your grievance and will notify you in writing of our grievance decision within 30 calendar days of our receipt of your appeal request.

- (2) **Expedited Grievance.** If your grievance concerns urgently-needed services, and the review timeframes specified above could result in adverse health effects, the procedure specified in paragraph (1) above does not apply. For urgently-needed services, you and your health care provider may request an expedited grievance either verbally, by calling Member Services, or in writing. We will review your appeal as expeditiously as possible, taking into account any medical exigencies. Within 72 hours of such request, we will provide notification of the outcome of our review. An urgent internal and external review appeal may occur at the same time.

4. **Independent Review Procedures**

- a. If we have made an Adverse Determination (defined above), you may request independent review of our decision if you request an external review within four months of the adverse determination. This provision may be waived if either of the following conditions applies:
- To initiate an external review process, you or your representative may submit a written request for an independent review to us.
 - Upon receipt of the request for independent review, the Independent Review Organization (“IRO”) 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 version 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 independent review must be made as soon as possible, but no later than 45 days after receipt of the request for independent review. Prompt written notice of the decision and the reasons for it must be sent to the enrollee and to us.

To be eligible for independent review, the treatment must be a covered benefit under this Plan, and you or your authorized representative must request the independent review as soon as possible, but not later than 4 months following the date of our Adverse Determination, Experimental Treatment Determination, or grievance panel decision, whichever is later.

- b. You or your authorized representative must send your written request for independent review to:

HealthPartners Insurance Company
Member Services Department
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: (952) 883-7000 1-866-443-9352

If you believe your request involves urgently-needed services, or if we mutually agree that your request should proceed directly to independent review, you should send your request to us.

- c. The IRO will notify you and us of its determination within 45 calendar days (or within 72 hours of its receipt of all needed information, if the independent review is expedited).
- d. The determination of the IRO is binding on you and on us. However, decisions regarding rescissions are not binding on the Insured.
5. **Office of the Commissioner of Insurance.** You may contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at <http://oci.wi.gov/>, or by writing to:

Office of the Commissioner of Insurance
Complaints Department
P. O. Box 7873
Madison, WI 53707-7873

or you can call 1-800-236-8517 outside of Madison or 266-0103 in Madison, and request a complaint form.

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, we have the right to recover the value of those services and payments made. This right shall be by reimbursement and subrogation. The right of reimbursement means you must repay us at the time you receive a recovery and we will be entitled to immediately collect the reasonable value of our payments from said settlement fund. 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.

The 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, medical payments coverage, any applicable umbrella coverage, other substitute coverage or any other right of recovery, whether based on tort, contract, equity or any other theory of recovery. The right of reimbursement is binding upon you, your legal representative, your heirs, next of kin and any beneficiary, trustee or legal representative of your heirs or next of kin in the event of your death. Any amounts you receive from such a recovery must be held in trust for our benefit to the extent of our subrogation claims.

You agree to cooperate fully in every effort by us to enforce our rights of reimbursement and subrogation. You also agree that you will not do anything to interfere with those rights. You are required by this contract to promptly inform us in writing of any potential or pending claim for recovery you may have on account of such injury or illness. Our rights under this part may be subject to and limited by, Wisconsin Law but are not limited by our right to recovery from another source. Our rights shall not be reduced by attorney's fees or any other costs of collection incurred by you. We may not have a right to recovery if you have not been made whole, after taking into consideration any comparative negligence. If a dispute arises over the question of whether or not you have been made whole, we have the right to a judicial determination of what dollar amount constitutes full recovery.

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 benefit 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). It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.

Each Certificate or other arrangement for coverage under (1) or (2) above 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 Parents.** 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 have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall follow the order of benefit determination rules outlined in subparagraph b. (2) above.
 - (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. above, "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 paragraph b. immediately below.
- b. **Reduction in This Plan's Benefits.** The benefits of This Plan will be reduced by the benefits that would be payable for the Allowable Expenses under the other plans, whether or not a claim is made. In no event will This Plan pay benefits which, combined with the benefits of the other plans, total more than the Allowable Expenses under This Plan. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

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

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

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

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. 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; reduction in the number of hours of employment; a situation in which an 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 eligibility for state premium assistance subsidy; 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 under a COBRA continuation provision 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 (or you, if not otherwise enrolled) 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.
3. You may also enroll yourself and any eligible dependents if you enroll within 30 days of any of the events listed below.
 - 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.

Newborn or Newly Adopted Child Enrollment. Your newborn child, or covered dependent's newborn child, is automatically covered for the first 60 days after birth. Your adopted child or child placed for adoption is covered for the 60 days immediately following the date the child is placed in your home or the date of the final court order granting the adoption. If premium is required to add the child for coverage under this Certificate you must notify us and send the required premium within 60 days of the child's birth, adoption or placement for adoption. If premium is not required to add the child under this Certificate, you should still notify us as soon as possible, so we can enroll the child in the plan.

If you do not notify us, or do not pay the required premium, within the initial 60 day period following birth, adoption or placement for adoption and you would like to add your child or grandchild for coverage, you may add the child for up to one year from the date of birth or adoption if you pay the required premium; premium payments that are past due may be subject to interest. If you do not add your child or grandchild within one year, that child will be considered a late entrant.

CHANGES IN COVERAGE

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

Any change in coverage 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 below called “qualifying events,” you may be eligible to continue group coverage, or to convert to non-group (individual) coverage.

CONTINUATION OF GROUP COVERAGE For Groups with 20 or more Employees

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. Termination of employment (except for gross misconduct) of the enrollee, or reduction in hours or change in job status resulting in a loss of group coverage.
 - b. Death of the enrollee.
 - c. Divorce or legal separation from the enrollee.
 - d. Loss of eligibility as a dependent child.
 - e. Initial eligibility of the enrollee for Medicare.
 - f. For a retired enrollee, spouse and other dependents, the bankruptcy filing by a former employer, under Title XI, United States Code, on or after July 1, 1986.

If your eligibility for group coverage under this Certificate ends because of a “qualifying event,” you may be eligible to continue group coverage. Each of these options is shown below.

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 or change in job status.** 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 paragraph b. “Earlier Termination” below.
 - (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 for the disabled person. 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.
 - (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.** The maximum period of continuation coverage is 36 months. Coverage continues until the occurrence of one of the events shown in paragraph b. “Earlier Termination” below.
 - (5) **Death of enrollee.** The maximum period of continuation coverage is 36 months. Coverage continues until the occurrence of one of the events shown in the paragraph b. “Earlier Termination” below.
 - (6) **Other qualifying events.** The maximum period of continuation coverage for all other qualifying events is 36 months.

- b. **Earlier Termination.** Coverage terminates before the end of the maximum period if any of the following occurs.
 - (1) **End of the plan.** The group health plan sponsor terminates the agreement under which this coverage is offered to its enrollees.
 - (2) **Failure to pay premium.** The person receiving continuation coverage does not make the monthly payment within 30 days of the due date.
 - (3) **Other group health coverage.** The person receiving continuation coverage becomes covered under any other group health type coverage, not containing an exclusion or limitation for any pre-existing condition of the person. If the other group health coverage contains a pre-existing condition limitation, continuation coverage is extended until the pre-existing limitation is satisfied or coverage is otherwise terminated. A person will not be subject to earlier termination of continuation coverage on account of coverage under another group plan that existed prior to that person's first day of continuation coverage.
 - (4) **Termination of extended coverage for disability.** In case a person receives extended (29-month) continuation coverage due to disability at the time of termination or reduced hours, the extended coverage terminates at the beginning of the month 30 days after a final determination that the person is no longer disabled.
 - (5) **Termination provisions of this Certificate.** The person receiving continuation coverage whose coverage is subject to the termination clause under the section of this Certificate titled, "TERMINATION".

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. 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.

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.

The Plan will comply with applicable federal law for a covered person that is called to active military duty in the uniformed services.

CONTINUATION OF GROUP COVERAGE For Groups with fewer than 20 Employees

If you have been continuously covered under the Plan for three (3) months and if your eligibility for group coverage under this Certificate ends because of one of the events below, called "qualifying events," you may be eligible to continue 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. Termination of employment (except for gross misconduct) of the enrollee, or reduction in hours or change in job status resulting in a loss of group coverage.
 - b. Death of the enrollee.
 - c. Divorce or legal separation from the enrollee.

- d. Loss of eligibility as a dependent child.
- e. Initial eligibility of the enrollee for Medicare.
- f. For a retired enrollee, spouse and other dependents, the bankruptcy filing by a former employer, under Title XI, United States Code, on or after July 1, 1986.

If your eligibility for group coverage under this Certificate ends because of a “qualifying event” you may be eligible to continue group coverage. Each of these options is shown below.

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 or change in job status.** The maximum period of continuation coverage is 18 months. Coverage continues until the occurrence of one of the events shown in paragraph b. “Earlier Termination” below.
 - (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, the maximum continuation period is 18 months.
 - (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.
 - (4) **Divorce or legal separation.** The maximum period of continuation coverage is 18 months. Coverage continues until the occurrence of one of the events shown in paragraph b. “Earlier Termination” below.
 - (5) **Death of enrollee.** The maximum period of continuation coverage is 18 months. Coverage continues until the occurrence of one of the events shown in paragraph b. “Earlier Termination” below.
 - (6) **Other qualifying events.** The maximum period of continuation coverage for all other qualifying events is 18 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 provisions of this Certificate.** The person receiving continuation coverage whose coverage is subject to the termination clause under the section of this Certificate titled, “TERMINATION”.
3. **Election of Continuation Coverage.**
 - a. You have 30 days to elect continuation of group coverage. The 30-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. 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 30 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 30 day period begins on the date of the divorce, legal separation, change in dependent status or second qualifying event.

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.

The Plan will comply with applicable federal law for a covered person that is called to active military duty in the uniformed services.

EXTENSION OF COVERAGE FOR DISABLED ENROLLEES

If the Group Policy terminates while you are totally disabled and you were covered under the Group Policy on the day prior to termination, your coverage under this Certificate will be extended until the earliest of:

1. The date your total disability ends.
2. The last day of the current contract year.
3. The date on which you have incurred eligible medical expenses equal to your lifetime maximum benefit.

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.

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.

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.
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 the section above titled, “Continuation of Group Coverage”.
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 the section above titled, “Continuation of Group Coverage”.
4. When this Certificate's maximum eligibility period under the group continuation coverage described in the section above titled, “Continuation of Group Coverage”, 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. If an enrollee knowingly gives false information on the application or if the enrollee otherwise misrepresents or omits a fact, and if that false information or omission is material to acceptance under this Certificate, this Certificate will automatically terminate on the date following 30 days' advance notice, provided discovery of the false information is made within 2 years of the date of enrollment.

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.

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

CLAIMS PROVISIONS

Notice of Claims. When a claim arises for services you have already received, you should notify us of the charges incurred in writing. This written notice of claim must be given within 20 days after any charges incurred, which are covered by this section, or as soon as reasonably possible. **Notice given to us by you or on behalf of you, at HealthPartners Insurance Company's principal office at 8170 33rd Avenue South, P.O. Box 1289, Minneapolis, MN 55440-1289, with information sufficient to identify you and the service, is deemed notice.**

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

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

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

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

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

Information. When you seek coverage for goods or services under this 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.

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

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

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 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 supersede state law.

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

Receive Information about Your Plan and Benefits

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

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