HealthPartners Insurance Company

HealthPartners Atlas Individual Policy

READ THIS POLICY CAREFULLY: The Individual Policy is a legal contract between you and HealthPartners Insurance Company. The Policy also provides, in detail, the rights and obligations of both you and HealthPartners Insurance Company.

Brian O'Shields, President	Nancy L. Evert, Secretary

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. 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 in the following order, depending on availability: 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 if a fee schedule in not available.

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 charges above the usual and customary charges, 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.

10-DAY RIGHT TO RETURN POLICY. You have the right to return this Policy to HealthPartners Insurance Company no later than the tenth day after you receive it. The Policy shall be returned to HealthPartners Insurance Company Attn.: Membership Accounting, 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309. HealthPartners Insurance Company will return all premium payments made for this Policy within ten days after receipt of notice of cancellation. However, any claims incurred by an insured prior to cancellation will be the insured's responsibility.

This Policy is guaranteed renewable except as otherwise provided herein.

Please save for future reference.

MGC-200.5-WI-IND
(MK-22)

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 952-883-5036 or 888-360-0622 number on your identification card or visiting HealthPartners' website at healthpartners.com.

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Pr.10-21

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 Policy. HealthPartners Insurance Company is a part of the HealthPartners family of related organizations. When used in this Policy, "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 network access and administrative services for HealthPartners Insurance Company.

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

IMPORTANT ENROLLEE INFORMATION

- You have the right to a grace period of 10 days for each premium payment due, when falling due after the first premium payment, during which period the Policy shall continue in force. If you are a recipient of the advance payment of the premium tax credit, you have a 3-month grace period. For more information see subsection titled, "Termination for Cause".
- 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 supplies are not covered. Read this Policy for a detailed explanation of all exclusions.
- Your spouse and any eligible dependents may purchase his or her own Policy under certain circumstances.
- Your coverage may be cancelled by you or us only under certain conditions. Read this Policy for the reasons for cancellation of coverage.

TERMS AND CONDITIONS OF USE OF THIS POLICY

- 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 INDIVIDUAL POLICY

INDIVIDUAL POLICY

The Individual Policy ("this Policy") is the enrollee's evidence of coverage, and is issued by HealthPartners Insurance Company. This Policy, the Benefits Chart, any amendments and the enrollment form are the whole agreement between HealthPartners Insurance Company and the enrollee. It covers the enrollee and the enrolled dependents (if any) as named on the enrollee's enrollment form. This Policy replaces an enrollee's prior Policy with HealthPartners Insurance Company, if any, as of the effective date of this Policy.

GUARANTEED RENEWAL

Coverage under this Policy begins on the effective date printed on or accompanying your initial identification card. This Policy is guaranteed to automatically renew annually thereafter if the required premium payment is made. Coverage continues until this Policy is replaced or terminated, as long as its conditions are met. By making premium payments or by having them made on your behalf, you accept the terms and provisions of this Policy. This Policy renews on the first day of each calendar year following your enrollment in the plan. Renewal is subject to our right to terminate your Policy due to your non-payment of premium or for fraud or intentional misrepresentation of a material fact, or as otherwise described in the section titled, "TERMINATION".

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

PREMIUM PAYMENTS

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

BENEFITS

This Policy provides HealthPartners Network Benefits **(Network Benefits)** underwritten by HealthPartners Insurance Company, when you seek medical services delivered by participating network providers. This Policy describes your Network Benefits and how to obtain covered services.

This Policy also provides HealthPartners Non-Network Benefits **(Non-Network Benefits)** underwritten by HealthPartners Insurance Company, for medical services delivered by non-network providers. This Policy describes your Non-Network Benefits and how to obtain covered services.

Applicable to Non-Network Benefits

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

If you are insured under this Policy 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 Policy is a Benefits Chart, which is incorporated and fully made a part of this Policy. It describes the amounts of payments and limits for the coverage provided under this Policy. 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 this 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. No change in this Policy shall be valid until approved by an executive officer of HealthPartners Insurance Company and unless such approval be endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

ENTIRE CONTRACT

The documents below constitute the entire contract of insurance between you and HealthPartners and replace all other agreements as of the effective date of this Policy:

- This Policy,
- The Benefits Chart, and any amendments, and
- Your Enrollment Form.

AMENDMENTS TO THIS POLICY

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

CONFLICT WITH EXISTING LAW

In the event that any provision of this Policy 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 Policy provides coverage for services provided by our network of participating providers and facilities.

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

Network providers are available to view free of charge by logging on to your "*my*HealthPartners" account at healthpartners.com. If you need assistance locating a physician or other health care providers in your network, please call Member Services.

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

Non-Network Providers. These are licensed physicians, dentists, mental health and substance use disorder 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 network providers. There are limited exceptions as described in this Policy.

HealthPartners Network. These are the health care providers, facilities and pharmacies contracted to provide services for your plan. They are described in the network directory.

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 Policy. Call Member Services for a current list.

In order to receive Network Benefits, the following services require using a Designated Physician, Provider or Facility:

- Contracted convenience care clinics are designated on our web site when you log on to your "*my*HealthPartners" 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.

- 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 administered in a clinic or an outpatient hospital, your physician and facility will obtain the Specialty Drugs from a designated vendor. 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.

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

HealthPartners Network Urgent Care Clinic. This is a participating clinic listed in your network directory, which provides medically necessary and appropriate urgent care, as covered in this Policy.

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

Continuity of Care. Under certain conditions set forth in state or federal law, in the event your current provider leaves the network, you may be eligible to continue to receive services from that provider and have such services be considered Network Benefits. Unless noted otherwise below, Network Benefits will apply until the earlier of the 90-day period beginning the date the provider contract is terminated or until the date on which you are no longer a continuing patient with that provider. Conditions that qualify for this benefit are:

- You are undergoing a course of treatment for a serious and complex condition;
- You are undergoing a course of institutional or inpatient care;
- You are scheduled to undergo nonelective surgery, including related care from such provider or facility with respect to such a surgery;
- You were determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and are receiving treatment for such illness;
- You are pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; if you are in the second or third trimester of pregnancy, services may be continued until the completion of postpartum care for you and the newborn child.

In addition, if the material/information provided to you included a primary care physician provider who is not a participating network provider, you may receive services from that provider until the end of the current plan year.

Continuity of care benefits will not be available or may be discontinued if the provider is terminated from the network for misconduct.

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

Prior Authorization for 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 "*my*HealthPartners" account at healthpartners.com for a list of which services require prior authorization.

Our medical directors, or their designees, make coverage determinations of medical 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 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 information regarding Complaint and Grievance Procedure in the section of this Policy titled, "DISPUTES AND COMPLAINTS" for a description of how to proceed.

ACCESS TO RECORDS AND CONFIDENTIALITY

We comply with the state and federal laws governing the confidentiality and use of protected health information and medical 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, the evaluation of potential or actual claims against us, auditing and legal services, and other health care operations and use without further authorization if permitted or required by another law.

DEFINITIONS OF TERMS USED

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 "*my*HealthPartners" account at healthpartners.com.

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

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 service or item, which is medically 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.

Eligible Dependents. These are the persons shown below. Under this Policy, 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 Policy may convert to his or her own Policy.

1. **Spouse.** This is an enrollee's current legal spouse.
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 who meets this requirement, coverage will continue for as long as the child is enrolled as 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.
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 and accepted by us as an insured per a signed enrollment form and is responsible for payment of premium.

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

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 a chiropractor, lawfully performing a medical 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 Policy.

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 Policy, and all of his or her eligible and enrolled dependents. When used in this Policy, "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.

Maintenance Drug. This is a formulary prescription drug which is included on a list of a limited number of prescription drugs which are commonly prescribed for long-term use. This list is designated by us, and is reviewed and modified periodically.

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 use disorder treatment services in accordance with governmental licensing privileges and limitations, who renders mental health or substance use disorder treatment services, as covered in this Policy. 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 Policy.

Policy Year. This is the 12-month period beginning on 12:01 A.M. Central Time on January 1, and ending 12:00 A.M, of the next following December 31. The Policy Year may be subject to change.

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 or experimental new drug. For Network Benefits, these drugs are considered part of the Formulary.

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, 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.

Renewal Date. The Renewal Date is the first day of each Policy Year following enrollment in this Policy.

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

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

SERVICES NOT COVERED

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

1. Treatment, procedures or services or drugs which are not medically necessary and/or which are primarily educational in nature or for your vocation, comfort, convenience, appearance, or recreation, including skills training.
2. Procedures, technologies, treatments, facilities, equipment, drugs and devices which are considered investigative or experimental, or otherwise not clinically accepted medical 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 Policy. In addition, transplant services by a Non-Network Provider are not covered.

   While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered.
3. Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders that are not evidence based.
4. Charges for Home Health Services by a Non-Network Provider.
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. Charges for Home Hospice Services by a Non-Network Provider are not covered.
6. Halfway houses, group homes, extended care facilities, shelter services, correctional services, detention services, transitional services, group residential services, foster care services, wilderness programs, and any comparable facilities, services or programs.
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 Policy.
9. Services from non-medically 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, to repair or reshape a body structure primarily for the improvement of your appearance or self-esteem, including, but not limited to, augmentation procedures, reduction procedures and scar revision. This exclusion does not apply to services for port wine stain removal and reconstructive surgery.
11. Dental treatment, procedures or services not listed in this Policy or Benefits Chart (see Dental Services in 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 Policy's requirement for medical necessity.
14. Infertility/fertility treatment, including but not limited to, office visits, laboratory services, diagnostic imaging services, and fertility drugs; reversal of sterilization; 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 Policy.
16. Elective abortions, except in the case of rape or incest, or in situations where the life of the mother would be endangered if the fetus is carried to full term.
17. Acupuncture.
18. Routine foot care unless the services meet our criteria for medically necessary care.
19. Vision correction surgeries such as keratotomy and keratorefractive surgeries, including LASIK surgery, except as specifically described in the medical coverage criteria.
20. Eyeglasses, contact lenses and their fitting, measurement and adjustment, except as specifically described in the Benefits Chart.

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. 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.
23. 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 our medical coverage criteria.
24. Drugs for the treatment of growth deficiency.
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 Policy.
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.
32. Health club memberships.
33. Massage therapy for the purpose of comfort or convenience of the insured.
34. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
35. Autopsies.
36. For Network Benefits, charges incurred for transplants received at facilities which are not designated facilities.
37. 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; or charges for accident-related dental services by a Non-Network Provider.
38. 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 logging on to your "*my*HealthPartners" account 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 months who are at risk for anemia.
39. Hair prosthesis (wigs).
40. Charges for phone, data, software or mobile applications/apps unless specifically described as covered in our medical coverage criteria for the device or service.
41. Charges for sales tax.
42. Charges for elective home births.
43. Professional services associated with substance use disorder interventions. A "substance use disorder intervention" is a gathering of family and/or friends to encourage a person covered under this Policy to seek substance use disorder treatment.
44. Services provided by naturopathic providers.
45. Commercial weight loss programs and exercise programs, and all weight loss/bariatric surgery.
46. Oral surgery to remove wisdom teeth.
47. Orthognathic treatment or procedures and all related services.
48. All drugs used for the treatment of sexual dysfunction.
49. Treatment, procedures, or services or drugs which are provided when you are not covered under this Policy.
50. Non-medical administrative fees and charges including but not limited to medical record preparation charges, appointment cancellation fees, after hours appointment charges, and interest charges.
51. Medical cannabis.
52. Routine eye exams for adults age 22 and older.

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 necessary for the proper treatment of an insured. Our medical directors, or their designees, make coverage determinations of medical necessity, restrictions on access and appropriateness of treatment, and they 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 directors. Coverage determinations for prescription drugs are based on requirements established by the HealthPartners Pharmacy and Therapeutics Committee, and are subject to periodic review and modification.

COMPLAINTS

1. **In General:** We have a complaint procedure to resolve 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. To start, you may call Member Services. This complaint process is available to enrollees, applicants, former enrollees, or any authorized representative acting on behalf of an enrollee, applicant or former enrollee seeking to resolve a concern which arose during the enrollee's membership or enrollment 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 under this Policy. Many complaints or questions can be resolved informally by calling Member Services.

   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 Policy;
   - Based on the information provided, we have denied payment for the treatment.

   Grievance. This is a written statement of dissatisfaction by you or your authorized representative pertaining to concerns about the provision of services, claims practices or benefit administration during your enrollment or application for enrollment on this Policy.

3. **Complaint and Grievance Procedure**

a. **Complaint Process**

If you have a concern and would like our assistance, you may call Member Services at 888-360-0622 to issue a complaint. Member Services will investigate the complaint and notify you or your authorized representative 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. In addition, 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, 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 Member Services 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 for review within 3 years of the adverse decision. Send your written request, 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 Rights & Benefits
8170 33rd Avenue South
P.O. Box 9463
Minneapolis, MN 55440-9463
FAX: 952-853-8742

Within 5 business days of receiving your request, we will send to you or your authorized representative a written notification stating we received your request.

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.

If the decision is to deny your request, 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 notify you in writing of our grievance decision within 30 calendar days of our receipt of your 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 request as expeditiously as possible, taking into account any medical exigencies. We will provide notification of the outcome of our review within 72 hours. An urgent internal and external review 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 date of the grievance resolution letter.

      - To initiate an external review process, you or your representative may submit a written request for an independent review to us. Send your request to:

        HealthPartners Insurance Company
        Member Rights & Benefits
        8170 33rd Avenue South
        P.O. Box 9463
        Minneapolis, MN 55440-9463
        FAX: 952-853-8742

        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.

      - 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 want to be considered. The enrollee or his or her authorized representative and HealthPartners Insurance Company shall be given an opportunity to present their 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.

   b. 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).

   c. 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
   PO Box 7873
   Madison, WI 53707-7873

   or you can call 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 Policy 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

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

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

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

- the persons we paid or for whom we have paid;
- insurance companies; or
- other organizations.

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

MEDICARE AND THIS POLICY

Medicare is a primary payer for Medicare enrollees who are eligible for Medicare because (a) they have reached age 65, or (b) are under age 65, and covered by Medicare because of disability or end stage renal disease.

The benefits under this Policy 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 Policy 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 Policy by the amount of any benefits available for such expenses under Medicare. This will be done before the benefits under this Policy are calculated. Charges for services used to satisfy an insured's Medicare Part B deductible will be applied under this Policy 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 Policy 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

Open Enrollment Period. During the open enrollment period November 1 – December 24 your coverage will be effective on January 1.

Special Enrollment Period. If you enroll during a special enrollment period, your coverage is effective:

1. In the case of birth, adoption or placement for adoption, or a child support order or other court order, coverage is effective on the date of birth, adoption or placement for adoption, or the date specified in a child support order or other court order;
2. In the case of marriage, coverage is effective the first day of the following month;

3. In the case where a qualified individual loses minimum essential coverage, coverage is effective the first day of the following month;
4. In the case of an individual gaining access to a new Qualified Health Plan due to a permanent move AND you had qualifying coverage for at least one day in the 60 days before your move, coverage is effective on the first of the month following the move;
5. For all other special enrollment period events listed below under the subsection titled, "Eligibility", coverage is effective:
    a. On the first day of the following month if your Qualified Health Plan selection is received between the first and the fifteenth day of any month; or
    b. On the first day of the second following month if your Qualified Health Plan selection is received between the sixteenth and the last day of any month.

ELIGIBILITY

You must enroll yourself and any eligible dependents during the annual open enrollment period or a special enrollment period to be covered under this Policy, except as specified below for a newborn or newly adopted child.

Open Enrollment Period. The open enrollment period begins on November 1 and extends through December 24. The annual open enrollment period and the date you have to enroll yourself and any eligible dependents are defined under federal law and may vary.

Special Enrollment Period. You are eligible to enroll outside of the open enrollment period if you qualify for a special enrollment period. The following events qualify for a special enrollment period:

1. You must enroll yourself and any eligible dependents within 30 days of any of the following HIPAA qualifying events listed under this item 1:
    - If you or your dependents lose group coverage because of termination of employment (except for gross misconduct) or reduction in hours.
    - If you or your dependents lose group coverage because of the death of the enrollee.
    - If you or your dependents lose group coverage because of divorce or legal separation.
    - If your dependent loses group coverage because of loss of eligibility as a dependent child.
    - If you or your dependents lose group coverage because the group enrollee's initial enrollment for Medicare.
    - 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.
2. You must enroll yourself and any eligible dependents within 60 days of any of the following ACA qualifying events listed below:
    - If you or any of your eligible dependents lose minimum essential coverage (failure to pay premium or a rescission of coverage allowed under federal law do not qualify as a loss of minimum essential coverage). If you or any of your eligible dependents lose minimum essential coverage, you may enroll anytime during the period starting 60 days prior to and ending 60 days following your loss of minimum essential coverage.
    - If you have any newly acquired dependents through marriage, birth, adoption, or placement for adoption, or through a child support order or other court order.
    - If you become a citizen, national or lawfully present individual in the U.S.
    - If you are qualified, but experience an error in enrollment.
    - If you are enrolled in another Qualified Health Plan and you successfully demonstrate to the Marketplace that your Qualified Health Plan has substantially violated a material provision of its Policy.
    - If you are newly eligible or lose eligibility for advance payment of the premium tax credit, or you experience a change in eligibility for cost sharing reductions.
    - If you become eligible for a new Qualified Health Plan offered through the Marketplace because of a permanent move and you had minimum essential coverage for one or more days during the 60 days prior to the permanent move.
    - If you are an Indian, as defined by section 4 of the Indian Health Care Improvement Act, you may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month.
    - If you are a qualified individual or enrollee and you demonstrate to the Marketplace, in accordance with the Department of Health Services guidelines, that you meet other exceptional circumstances as the Marketplace may provide, you may enroll in a Qualified Health Plan.

Late Enrollment. If you do not enroll yourself or any eligible dependents during the open enrollment period or a special enrollment period, you must wait until the next annual open enrollment period to enroll yourself and any eligible dependents.

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. Coverage is effective from the date of birth or adoption (or date of placement for adoption). If premium is required to add the child for coverage under this Policy 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 Policy, 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

All changes to the Policy must be approved by us. No agent can legally change the Policy or waive any of its terms.

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

TERMINATION

Termination of coverage for the enrollee constitutes automatic termination of coverage for all of the enrollee's enrolled dependents, unless otherwise specified by the enrollee.

VOLUNTARY TERMINATION

You may cancel your Marketplace plan any time. To cancel this Policy, contact the Marketplace Call Center. In most cases coverage ends immediately, but not always. Once you terminate this Policy, you cannot re-enroll until the next annual open enrollment period (unless you qualify for special enrollment period). The best way to make sure coverage ends on the right date is to contact the Marketplace Call Center and request the change.

INVOLUNTARY TERMINATION

We may terminate your coverage under this Policy if any of the following apply:

- If we no longer offer coverage in the individual market, subject to 180 days advance notice of termination.
- If we terminate a particular plan or product, subject to 90 days advance notice of termination. In this case, you would be able to select a different plan or product.
- If you move outside of our service area, subject to 31 days advance notice of termination.
- If an enrolled dependent no longer meets this Policy's definition of eligible dependent, coverage for that dependent terminates on the last day of the month in which the dependent's eligibility ceases.
- To the extent that a termination would be considered a rescission under state or federal law under the last bulleted item we are required to give you 30 days advance notice of termination.
- If we receive information from the Marketplace to terminate your coverage.

We cannot renew your coverage with us if the following applies:

- If we have knowledge that you are entitled to Medicare Part A or enrolled in Medicare Part B and renewal of individual coverage with us through a different policy or contract would duplicate benefits for which you are otherwise entitled, then any renewal of your individual coverage with us through a different policy or contract is prohibited by federal law and cannot be renewed.

TERMINATION FOR CAUSE

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

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

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

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

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

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

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

At our option, all payments for claims may be made directly to the provider of medical 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 care pursuant to a court order, provided we are informed of such order. This payment will discharge us from all further liability to the extent of the payment made.

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

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

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