HealthPartners®

HealthPartners Peak Individual Plan Membership Contract

READ THIS CONTRACT CAREFULLY: This Contract is a legal contract between you and Group Health Plan, Inc. This Contract also provides, in detail, the rights and obligations of both you and Group Health Plan, Inc.

RIGHT TO EXAMINE AND CANCEL

You may cancel this Contract by delivering or mailing a written notice to GHI or an agent of GHI, no later than the tenth day after you receive this Contract. Notices may be delivered or sent to GHI Attn.: Membership Accounting, 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309. Notice of cancellation given by mail and return of Contract given by mail are effective if they are properly addressed, postage prepaid and postmarked within the ten day time period shown above. GHI will return all payments made for this Contract, including fees or charges, within ten days after receipt of notice of cancellation. This Contract will be considered void from the effective date of coverage, and you will be in the same position as if this Contract had never been issued to you. However, any claims incurred by an insured prior to cancellation will be the member's responsibility.

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)

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

Additional languages listed on page 2

Oromiffa *(Cushite [Oromo])*
XIYYEEFFANNAA: Afaan dubbattu Oromiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-883-2177. (TTY: 711)

Italiano *(Italian)*
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)

አማርኛ *(Amharic)*
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-883-2177. (መስማት ለተሳናቸው: 711)

ภาษาไทย *(Thai)*
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-883-2177. (TTY: 711)

unD *(Karen)*
ဟ်သူဉ်ဟ်သး– နမ့ါကတိၤ ကညီ ကျိာ်အယိ, နမၤန့ါ ကျိာ်အတ်မၤစၢၤလၢ တလာ်ဘူဉ်လာ်စ့ၢ နီတမံၤဘဉ်သ့နှဉ်လိၤ. ကိး 1-800-883-2177. (TTY: 711)

ελληνικά *(Greek)*
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-883-2177. (TTY: 711)

ខ្មែរ *(Mon-Khmer, Cambodian)*
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-883-2177. (TTY: 711)

Diné Bizaad *(Navajo)*
Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-883-2177. (TTY: 711)

Deitsch *(Pennsylvanian Dutch)*
Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-883-2177. (TTY: 711)

Ikirundi *(Bantu – Kirundi)*
ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-883-2177. (TTY: 711)

Polski *(Polish)*
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-883-2177. (TTY: 711)

Kiswahili *(Swahili)*
KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-883-2177. (TTY: 711)

हिंदी *(Hindi)*
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-883-2177. (TTY: 711)

日本語 *(Japanese)*
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。

Shqip *(Albanian)*
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-883-2177. (TTY: 711)

नेपाली *(Nepali)*
ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-883-2177 (टिटिवाइ: 711)

Srpsko-hrvatski *(Serbo-Croatian)*
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-883-2177. (TTY: 711)

Norsk *(Norwegian)*
MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-883-2177. (TTY: 711)

ગુજરાતી *(Gujarati)*
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-883-2177. (TTY: 711)

Adamawa *(Fulfulde, Sudanic)*
MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-883-2177. (TTY: 711)

اُردُو *(Urdu)*
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).

Українська *(Ukranian)*
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-883-2177. (телетайп: 711)

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HEALTHPARTNERS MISSION

TO IMPROVE HEALTH AND WELL-BEING IN PARTNERSHIP WITH OUR MEMBERSM PATIENTS AND COMMUNITY

ABOUT GROUP HEALTH PLAN, INC., HEALTHPARTNERS, INC. and HEALTHPARTNERS INSURANCE COMPANY

Group Health Plan, Inc. (GHI). GHI is a non-profit corporation which is licensed by the State of Minnesota as a Health Maintenance Organization (HMO). GHI underwrites the HMO Benefits described in this Contract. GHI is a part of the HealthPartners family of related organizations. When used in this Contract, "we", "us" or "our" has the same meaning as "GHI" and its related organizations.

HealthPartners, Inc. (HealthPartners). HealthPartners is a non-profit corporation which is licensed by the State of Minnesota as a Health Maintenance Organization (HMO). HealthPartners administers the HealthPartners Benefits described in this Contract. HealthPartners is the parent company of a family of related organizations and provides administrative services for Group Health Plan, Inc.

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

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

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

IMPORTANT ENROLLEE INFORMATION FOR NETWORK SERVICES:

- COVERED SERVICES. These are network services provided by participating network providers or authorized by those providers. This Contract fully defines what services are covered and describes procedures you must follow to obtain coverage.
- PROVIDERS. Enrolling with us does not guarantee services by a particular provider on the list of network providers. When a provider is no longer part of the network, you must choose among remaining Network providers.
- EMERGENCY SERVICES. Emergency services from providers outside the network will be covered if proper procedures are followed. Read this Contract for the procedures, benefits and limitations associated with emergency care from network and non-network providers.
- EXCLUSIONS. Certain services or medical supplies are not covered. Read this Contract for a detailed explanation of all exclusions.
- CANCELLATION. Your coverage may be cancelled by you or us only under certain conditions. Read this Contract for the reasons for cancellation of coverage.
- NEWBORN COVERAGE. If your health plan provides for dependents coverage, a newborn infant is covered from birth. We will not automatically know of the newborn's birth or that you would like coverage under your plan. You should notify us of the newborn's birth and that you would like coverage. If your Contract requires an additional enrollment payment for each dependent, we are entitled to all enrollment payments due from the time of the infant's birth until the time you notify us of the birth. We may withhold payment of any health benefits for the newborn infant until any enrollment payments you owe are paid.
- PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT. Enrolling with us does not guarantee that any particular prescription drug will be available or that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the Contract year.

ENROLLEE BILL OF RIGHTS FOR NETWORK SERVICES

- Enrollees have the right to available and accessible services including emergency services 24 hours a day and seven days a week.
- Enrollees have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice.
- Enrollees have the right to refuse treatment, and the right to privacy of medical and financial records maintained by us and our health care providers, in accordance with existing law.
- Enrollees have the right to file a complaint with us and the Commissioner of Health and the right to initiate a legal proceeding when experiencing a problem with us or our health care providers.
- Enrollees 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 this contract 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, as described in the "Termination" section under subsection "Termination for Cause".
- Medicare enrollees have the right to voluntarily disenroll from coverage and the right not to be requested or encouraged to disenroll, except in circumstances specified in federal law.
- Medicare enrollees have the right to a clear description of nursing home and home care benefits covered by us.

TERMS AND CONDITIONS OF USE OF THIS CONTRACT

- This Contract may be available in printed and/or electronic form.
- Only GHI is authorized to amend this Contract.
- Any other alteration to a printed or electronic Contract is unauthorized.
- In the event of a conflict between printed or electronic Contracts only the authorized Contract will govern.

INTRODUCTION TO THE MEMBERSHIP CONTRACT

MEMBERSHIP CONTRACT

This Membership Contract (this Contract) is the enrollee's evidence of coverage, issued by Group Health Plan, Inc. This Contract, the Benefits Chart, any amendments and the enrollment form are the whole agreement between Group Health Plan, Inc. and the enrollee. It covers the enrollee and the enrolled dependents (if any) as named on the enrollee's enrollment form. This Contract replaces all contracts previously issued by us. By making enrollment payments, you accept the provisions of this Contract.

This Contract replaces an enrollee's prior Contract with Group Health Plan, Inc., if any. Coverage under this Contract begins on the effective date printed on or accompanying your initial identification card. This Contract is guaranteed to automatically renew annually thereafter if the required premium payment is made. You are required to pay all outstanding premium payments due for any prior HealthPartners Coverage you received for the 12-month period preceding the effective date of any new coverage. We do not have to renew your coverage under this Contract if you do pay this premium.

It may only be terminated as described in the "Termination" section. Coverage continues until this Contract 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 Contract. This Contract renews on the first day of each calendar year following your enrollment in the plan.

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

IDENTIFICATION CARD

An identification card will be issued to you at the time of enrollment. You will be asked to present your identification card, or otherwise show that you are a member, 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 Contract. In addition, you may not, in any way, assign or transfer your right to pursue any causes of action arising under this Contract including, but not limited to, causes of action for denial of benefits under this Contract.

ENROLLMENT PAYMENTS

Coverage under this Contract is conditioned on our regular receipt of payments for all enrollees. Enrollment payments are based upon the contract type and the number and status of any dependents enrolled with the enrollee.

Enrollment 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 Contract. Your enrollment payments usually change annually on your Renewal Date (which may be different than your effective date), subject to 30 days notice. Your enrollment payments may change during the year if you add or terminate coverage for any dependents. We will bill you for your pre-payment on a monthly cycle.

BENEFITS

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

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

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

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

CHANGES IN BENEFITS

We are permitted to change benefits under this Contract to maintain compliance with federal and state law, subject to 30 days notice prior to the change. 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, coinsurance and out-of-pocket limit values on an annual basis to reflect cost of living increases.

AMENDMENTS TO THIS CONTRACT

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

CONFLICT WITH EXISTING LAW

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

HOW TO USE THE NETWORK

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

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

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

If a Network Provider refuses to continue to provide care to you, we shall furnish you with the name, address, and telephone number of other participating providers in the same area of medical specialty.

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 contact Member Services.

Provider Network Notifications. We are required to update our online provider directory on a monthly basis with any changes to our provider network, including provider changes from in-network status to non-network status.

If you tell us that your service was provided before our online provider directory was updated to remove your provider from our network, we must reprocess your claim to pay benefits at the in-network benefit level, unless we notified you directly of the network change prior to the service being provided. This paragraph does not apply if we are able to verify that our online provider directory displayed the correct provider network status at the time the service was provided.

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

ABOUT THE NETWORK

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

Network. 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 contract. 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 website 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 shown in the 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 or 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.

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

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

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

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

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

Conditions that qualify for this benefit are:

- an acute condition;
- a life-threatening mental or physical illness;
- pregnancy for which you have begun care;
- a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or
- a disabling or chronic condition that is in an acute phase.

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

Terminally ill patients are also eligible for continuity of care benefits. Continuity of care may continue for the rest of the enrollee's life if a physician, advanced practice registered nurse, or physician assistant certifies that the enrollee has an expected lifetime of 180 days or less.

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.

Authorizations for Network Services. There is no referral requirement for services delivered by providers within your network. Your physician may be required to obtain prior authorization for certain services. Your physician will coordinate the prior authorization process for any services which must first be prior authorized. You may call Member Services or log on to your "*my*HealthPartners" account at healthpartners.com for a list of which services require your physician to obtain prior authorization. You also must obtain prior authorization from us to see non-network providers for the care delivered by non-network providers to be covered as Network Benefits.

Our medical or dental directors, or their designees, make coverage determinations of medical necessity and make final authorization for covered services. Coverage Determinations are based on established medical or dental policies, which are subject to periodic review and modification by the medical or dental directors.

When a prior authorization for a service is required, we will make an initial determination within 5 business days, provided that all information reasonably necessary to make a determination on the request has been available to us.

When a prior authorization for an urgent service is required, we will make an initial determination within 48 hours after the initial request unless more time is required to ensure that our time for making a determination includes at least one business day.

If the enrollee or provider do not provide information necessary to make a determination on the request, we may make an adverse determination.

If the determination is made to authorize the service, we will notify your health care provider by telephone, by facsimile to a verified number or by electronic mail to a secure electronic mail box.

When an adverse determination is made, notification must be provided within 5 business days of the receipt of the request by telephone, by facsimile to a verified number, or by electronic mail to a secure electronic mailbox to the attending health care professional and hospital or physician office as applicable.

Written notification with details of the denial will be sent to the hospital or physician office as applicable and attending health care professional. Written notification with details of the denial will be sent to the enrollee and may be sent by United States mail, facsimile to a verified number, or by electronic mail to a secure mailbox.

If you want to request an expedited review, or have received an adverse determination 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 Complaints and Appeals in section "Disputes and Complaints" for a description of how to proceed.

HMO Formulary Exception Process. You or your provider can request an exception to our formulary. If the request is approved, the non-formulary drug you are requesting would be covered. Requests are generally reviewed and responded on the day they are requested. Decisions are made on a case-by-case basis. You or your provider can request an exception using the Prior Authorization/Exception form on our website or by calling Member Services. We review exception requests based on diagnosis, formulary medicines that you have already tried, evidence that the medicine you want to take is effective and medical necessity. If we do not approve your request, you can request an exception review, as described in the Complaints section of this contract.

Formulary Exception Process for Antipsychotic Drugs. If you are prescribed an Antipsychotic drug, we must promptly grant you an exception to our formulary when your health care provider indicates to us that:

- the formulary drug causes an adverse reaction to the patient;
- the formulary drug is contraindicated for the patient; or
- the health care provider demonstrates that the prescription drug must be dispensed as written to provide maximum medical benefit to the patient.

The formulary, and information on drugs that require authorization, are available by calling Member Services, or logging on to your "*my*HealthPartners" account at healthpartners.com.

Formulary Changes. The formulary may change throughout the year. If you are affected by a formulary change, you will receive at least 30 days' advanced notice of that change, and you may request a formulary exception.

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

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

1. **Standard Exception Request.** If your provider prescribes a drug that is not on our formulary, you may submit a standard exception request. If you, your designee or your prescribing provider submit a standard exception request, we must make our coverage determination and notify you within 72 hours of our receipt of the request. If we grant the exception to cover the drug, we are required to cover the drug for the duration of the prescription, including refills.

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

3. **Federal External Review Exception Request.** If coverage of the drug is denied after an exception request review under item 1. or 2. above, you may request an external review exception request. If the initial request was a standard exception request, we must notify you or your designee and the prescribing provider of the coverage determination within 72 hours of our receipt of your request for external review. If the initial request was an expedited exception request, we must notify you or your designee and the prescribing provider of the coverage determination within 24 hour of our receipt of your request of external review. If you are granted an exception after the external review exception request, we are required to cover the drug for the duration of the prescription, if the initial request was a standard exception request. If the initial request was an expedited exception request, we must provide coverage for the duration of the exigency.

4. **State External Review Request.** If coverage of the drug is denied after a federal external review exception request under item 3. above, you may request an external review under section "Disputes and Complaints", subsection "Complaints", item 4. "External Complaints Procedures".

DISCLOSURE OF PAYMENTS FOR HEALTH CARE SERVICES

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

STEP THERAPY OVERRIDE PROCESS

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

A member, or the prescribing health care provider if designated by a member, may appeal if they deny a step therapy override request by using the complaint procedure under section "Disputes and Complaints."

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

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

UNAUTHORIZED PROVIDER SERVICES

1. Except as provided in paragraph 3, unauthorized provider services occur when you receive services:
   a. From a non-network provider at a network hospital or ambulatory surgical center, when the services are rendered:
      (1) Due to unavailability of a network provider;
      (2) By a non-network provider without your knowledge; or
      (3) Due to the need for unforeseen services arising at the time services are being rendered; or

   b. From a network provider that sends your specimen from the network provider's practice setting to a non-network laboratory, pathologist, or other medical testing facility.

2. Unauthorized provider services do not include emergency services as defined in Minnesota Statute 62Q.55, subdivision

3. The services described in paragraph 1, clause (b) are not unauthorized provider services if you give advance written consent to the provider acknowledging that the use of a provider, or the services to be rendered, may result in costs not covered by the health plan.

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

You may submit claims for unauthorized provider services (as defined in item 1. above). See section "Claims Provisions", subsection "Notice of Claims" for instructions on how to submit a claim.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

You have rights to parity in mental health and substance use disorder treatment as required by the federal Mental Health Parity and Addiction Equity Act and Minnesota Statutes, section 62Q.47. These laws require that:

- Mental health and substance abuse services covered on the same basis as medical services;
- That cost-sharing for mental health and substance abuse services can be no more restrictive than cost-sharing for similar medical services;
- That treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services;
- That if enrollees have concerns they can call Member Services, file a complaint with HealthPartners, or file a complaint with Minnesota Department of Health.

PRIOR AUTHORIZATION OF SERVICES

If we require prior authorization of a service, the following rules apply:

- If the service is ordered by a Network Provider, the Network Provider is responsible for prior authorizing the service with us. If the Network Provider does not prior authorize the service with us, we will cover the service with no reduction in benefits to you.
- If the service is ordered by a Non-Network Provider, you or the Non-Network Provider are responsible for prior authorizing the service with us. If you or the Non-Network Provider do not prior authorize the service with us, the service will be subject to a retrospective review to see if it meets the definition of medically necessary care. If it is determined to be medically necessary, it will be covered at the non-network benefit level. If it is determined to be not medically necessary, you will be responsible for the cost of the service.

If you received prior authorization for services under the prior plan, we will accept that prior authorization for the first sixty days of coverage under this plan.

You can find the list of services that require prior authorization at healthpartners.com

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, the evaluation of potential or actual claims against us, auditing and legal services, and other health care operations. When you enrolled for coverage, you authorized our access to use your records as described in this paragraph, and this authorization remains in effect unless it is revoked.

DEFINITIONS OF TERMS USED

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

Adverse Determination. This means a decision made by us or our designee relating to an admission, extension of stay, or health care service that is partially or wholly adverse to the enrollee, including a decision to deny an admission, extension of stay, or health care service on the basis that it is not medically necessary.

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.

Calendar Year. This is the 12-month period beginning 12:01 A.M. Central Time, on January 1, and ending 12:00 A.M. Central Time of the next following December 31.

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

Clinically Accepted Medical Services. These are techniques or services that have been determined to be effective for general use, based on risk and medical implications. Some clinically accepted techniques are approved only for limited use, under specific circumstances.

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

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

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

Custodial Care. This is supportive services focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including but not limited to, bathing, dressing and feeding.

Dentally Necessary Care. This is care which is limited to diagnostic testing, treatment, and the use of dental equipment and appliances which, in the judgment of a dentist, is required to prevent deterioration of dental health, or to restore dental function. The member's general health condition must permit the necessary procedure(s). Decisions about dental necessity are made by the HealthPartners Dental Director or his or her designee.

Eligible Dependents. These are the persons shown below. Under this Contract, a person who is considered an enrollee is not qualified as an eligible dependent.

1. **Spouse.** This is an enrollee's current legal spouse. If both married spouses are covered as enrollees under this Contract, only one spouse shall be considered to have any eligible dependents.

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

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

3. **Qualified Grandchild.** This is a covered grandchild of an enrollee or an enrollee's spouse who is financially dependent upon the covered grandparent and resides with that covered grandparent continuously from birth. The grandchild must be either under 26 years of age or a disabled dependent, as described below.

4. **Disabled Dependent.** This is an enrollee's dependent who is (a) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and (b) chiefly dependent on the enrollee for support and maintenance. 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.

Emergency Service. This means a health care service necessary to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part.

Enrollee. This is a person who (1) resides in the service area; (2) enrolls through the Marketplace; (3) is eligible and accepted by us as a member per a signed enrollment form; and (4) is responsible for payment of enrollment payments.

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 Care. This is speech, physical or occupational therapy which is rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development. To be considered habilitative, measurable functional improvement and measurable progress must be made toward achieving functional goals, within a predictable period of time toward a member's maximum potential ability.

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

Health Care Service: This means:

- a health care procedure, treatment, or service provided by a health care facility or a physician office;
- a health care procedure, treatment, or service provided by a doctor of medicine, doctor of osteopathy, or other health professional within the scope of the practice for that professional; or
- the provision of pharmaceutical products or services, medical supplies, or durable medical equipment.

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 a 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 a member chooses to receive care in a private room under circumstances in which it is not medically necessary, our payment toward the cost of the room shall be based on the average semi-private room rate in that facility.

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

- 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 or ongoing Phase I, II or III clinical trials; and
- Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether a drug is included in any authoritative compendia as identified by the Medicare program for use in the determination of a medically necessary accepted indication of drugs and biologicals used off-label, as appropriate for its proposed use; and
- Whether there are consensus opinions of national and local health care providers in the applicable specialty as determined by a sampling of providers, including whether there are protocols used by the treating facility or another facility studying the same drug, device, medical treatment or procedure.

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

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

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

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

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

Membership Application: You may apply for coverage under this Contract online by completing an application form. You may apply directly with us or through MNsure Marketplace. The information you provide when you apply is incorporated and made fully a part of this Contract. You must provide full and complete information when you apply. We must accept you and your dependents as members for coverage under this Contract to be effective.

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 service in accordance with governmental licensing privileges and limitations, who renders mental health or substance use disorder services to our members as covered in this Contract. For inpatient services, these mental health professionals must be working under the order of a physician.

Outpatient. This is medically necessary diagnosis, treatment, services or supplies provided by a hospital's outpatient department, or a licensed surgical center and other ambulatory facility (other than in any physician's office).

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

Prescription Drug. This is any medical substance for prevention, diagnosis or treatment of injury, disease or illness approved and/or regulated by the Federal Food and Drug Administration (FDA). It must (1) bear the legend: "Caution: Federal Law prohibits dispensing without a prescription" or "Rx Only"; and (2) be dispensed only by authorized prescription of any physician or legally authorized health care provider under applicable state law. 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. However, you may request coverage for a drug that is newly approved by the FDA by requesting an exception to the formulary under the formulary exception process described in the definition of formulary in the Benefits Chart.

Prior Authorization. This means a determination by our medical directors, or their designees, that an admission, extension of stay, or other health care service has been reviewed and that, based on the information provided, it satisfies our utilization review requirements. We will then pay for the covered benefit, provided the general exclusion provisions, and any deductible, copayment, coinsurance, or other policy requirements have been met.

Reconstructive Surgery. This is limited to reconstructive surgery, incidental to or following surgery, resulting from injury or illness of the involved part, or to correct a congenital disease or anomaly resulting in functional defect in a dependent child, as determined by the attending physician.

Rehabilitative Care. This is a restorative service, which is provided for the purpose of obtaining significant functional improvement, within a predictable period of time, (generally within a period of two months) toward a patient's maximum potential ability to perform functional daily living activities.

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

SERVICES NOT COVERED

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

1. Treatment, procedures or services or drugs which are not medically necessary and/or which are primarily educational in nature or for the vocation, comfort, convenience, appearance or recreation of the member, including skills training.
2. For Network coverage, treatment, procedures or services which are not provided by a network physician or other authorized network provider. There are certain exceptions, as described in "Emergency and Urgently Needed Care Services" and "Specified Non-Network Services".
3. Procedures, technologies, treatments, facilities, equipment, drugs and devices which are considered investigative, or otherwise not clinically accepted medical services. We consider the following transplants to be investigative and do not cover them: surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, non-human organ implants and/or transplants and other transplants not specifically listed in this Contract. While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered.
4. Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders, including ABA, IEIBT and Lovaas.

5. Rest and respite services and custodial care, except as respite services are specifically described in the Benefits Chart under the section “Home Hospice Services”. This includes all services, medical equipment and drugs provided for such care.
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.
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, primarily for the improvement of the member's appearance or self-esteem. This exclusion does not apply to services for port wine stain removal and reconstructive surgery.
11. Dental treatment, procedures or services not listed in this Contract.
12. Vocational rehabilitation and recreational or educational therapy. Recreation therapy is therapy provided solely for the purpose of recreation, including but not limited to: (a) requests for physical therapy or occupational therapy to improve athletic ability, and (b) braces or guards to prevent sports injuries.
13. Health services and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise medically necessary, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) competency evaluations, and adoption studies.
14. Court ordered treatment, except as described under the Benefits Chart section “Behavioral Health Services” and section “Office Visits for Illness or Injury” or as otherwise required by law.
15. Fertility treatment, including but not limited to office visits, laboratory services, and 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.
16. Services related to the establishment of surrogate pregnancy and fees for a surrogate are not covered. Pregnancy and maternity services are covered for a member under this Contract.
17. Routine foot care, except as they meet criteria for medically necessary care.
18. 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. Communications 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.
21. Hearing aids (implantable and external, including osseointegrated or bone anchored) and their fitting except as specifically described in this Benefits Chart. This exclusion does not apply to cochlear implants.
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, except as required by Minnesota law. This exclusion does not apply to special dietary treatment for Phenylketonuria (PKU) or oral amino acid based elemental formula or other items if they meet our medical coverage criteria.
23. Services provided by a family member of the enrollee, or a resident in the enrollee's home.
24. Religious counseling; marital/relationship counseling and sex therapy.
25. Private duty nursing services. This exclusion does not apply if covered person is also covered under Medical Assistance under Minnesota chapter 256B to the extent that the services are covered under section 256B.0625, subdivision 7, with exception of section 256B.0654, subdivision 4.
26. Services that are provided to a member, who also has other primary insurance coverage for those services and who does not provide us the necessary information to pursue Coordination of Benefits, as required under this Contract.
27. The portion of a billed charge for an otherwise covered service by a non-network provider, which is in excess of the usual and customary charges. We also do not cover charges or a portion of a charge which is either a duplicate charge for a service or charges for a duplicate service.
28. Charges for services (a) for which a charge would not have been made in the absence of insurance or health plan coverage, or (b) which the member is not legally obligated to pay, and (c) from providers who waive copayment, deductible and coinsurance payments by the member, except in cases of undue financial hardship.

29. Provider and/or member travel and lodging incidental to travel, regardless if it is recommended by a physician.
30. Health club memberships.
31. Massage therapy for the purpose of comfort or convenience of the member.
32. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
33. Autopsies.
34. 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.
35. For Network coverage, charges incurred for transplants provided by a facility that is not a designated transplant center, Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) received at facilities which are not designated facilities, or charges incurred for weight loss services provided by a physician who is not a designated physician.
36. 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 restorations; or (5) received beyond twenty-four months from the date of injury.
37. 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. We cover off-label use of drugs to treat cancer as specified in the "Prescription Drug Services" section of this Contract. This exclusion does not include over-the-counter contraceptives for women as allowed under the Affordable Care Act when the member obtains a prescription for the item. In addition, if 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 of anemia.
38. Charges for sales tax.
39. Charges for elective home births.
40. 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 Contract to seek substance abuse treatment.
41. Services provided by naturopathic providers.
42. Oral surgery to remove wisdom teeth.
43. Acupuncture.
44. All drugs used for the treatment of sexual dysfunction.
45. Orthognathic treatment or procedures and all related services, unless it is required to treat TMD or CMD and it meets our medical coverage criteria.
46. Commercial weight loss programs and exercise programs and all weight loss/bariatric surgery.
47. Routine eye exams for adults age 22 and older.
48. Treatment, procedures, or services or drugs which are provided when you are not covered under this Contract.
49. Medical cannabis.
50. Non-medical or non-dental administrative fees and charges included but not limited to medical or dental record preparation charges, appointment cancellation fees, after hour’s appointment charges and interest charges.
51. Drugs on the Excluded Drug List are not covered. 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. However, you may request coverage for a drug on the Excluded Drug List by requesting an exception to the formulary under the formulary exception process described in the definition of formulary in the Benefits Chart. The Excluded Drug List is available at healthpartners.com.
52. Drugs that are newly approved by the FDA until they are reviewed and approved by HealthPartners Pharmacy and Therapeutics Committee. However, you may request coverage for a drug that is newly approved by the FDA by requesting an exception to the formulary under the formulary exception process described in the definition of formulary in the Benefits Chart.
53. Hair prostheses (wigs), except as specifically described in the Benefits Chart.
54. Charges for phone, data, software or mobile applications/apps unless specifically described as covered in our medical coverage criteria for the device or service.
55. Medical devices approved by the FDA will not be covered under the Prescription Drug Services section unless they are on the formulary. Covered medical devices are generally submitted and reimbursed under your medical benefits.

DISPUTES AND COMPLAINTS

DETERMINATION OF COVERAGE

Eligible services are covered only when medically necessary for the proper treatment of a member. Our medical or dental directors, or their designees, make coverage determinations of medical necessity, restrictions on access and appropriateness of treatment, and they make final authorization for covered services. Coverage Determinations are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. Covered prescription drugs are based on requirements established by the HealthPartners Pharmacy and Therapeutics Committee, and are subject to periodic review and modification.

COMPLAINTS

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

2. **Definitions:**

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

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

3. **Complaint and Appeal Process:**

   a. Complaints:

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

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

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

   b. Appeal Process:

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

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

   GHI
   Member Services Department
   8170 33rd Avenue South
   P.O. Box 9463
   Minneapolis, MN 55440-9463
   Telephone: (952) 883-5900 Outside the metro area: 855-813-3887

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

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

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

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

   Appeals Involving Medical Necessity Determinations.

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

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

   This time period may be extended for up to 4 days if, due to circumstances beyond our control, we are unable to make the decision within the 15-day period. If we request an extension we will notify you in advance of the extension and the reasons for the extension.

   All Other Appeals

   A decision on your appeal will be made within 30 calendar days.

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

   All notifications described above will comply with applicable law.

2. **Second Level Appeal.** If you file a first level appeal and it is denied, wholly or in part, you have the right to request external review of our decision without filing a second level appeal. See below for a description of this process. If your appeal does not involve a determination of medical necessity, at your option**,** you or your authorized representative may, within 180 days of denial submit a written request for a second level appeal, including any relevant documents, and submit issues, comments and additional information as appropriate to:

   GHI
   Member Services Department
   8170 33rd Avenue South
   P.O. Box 9463
   Minneapolis, MN 55440-1309
   Telephone: (952) 883-5900 Outside the metro area: 855-813-3887

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

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

These time periods may be extended if you agree.

4. External Complaint Procedures:

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

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

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

The external review entity must make its expedited determination to uphold or reverse the adverse determination as expeditiously as possible but within no more than 72 hours after the receipt of the request for expedited review and notify the enrollee and the health plan company of the determination.
If the external review entity's notification is not in writing, the external review entity must provide written confirmation of the determination within 48 hours of the notification.

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

- If your complaint is denied based on our medical necessity criteria, you have the right to request external review upon receiving notice of our decision on your complaint. If your complaint is denied for any other reason, you have the right to request external review upon notice of our decision at the completion of your first level appeal. However, if the complaint relates to a malpractice claim, the complaint shall not be subject to the Internal Complaint Process.
- To initiate the external review process, you may submit a written request for an external review to the Commissioner of Health (Commissioner of Commerce). This written request must be accompanied by a $25 filing fee payable to the Commissioner. This fee may be waived by the Commissioner in cases of financial hardship. We must participate in this external review, and must pay the cost of the review which exceeds the $25 filing fee. If the adverse determination is completely reversed, the filing fee must be refunded. Filing fees are limited to $75 in a contract year.
- Upon receipt of the request for external review, the external reviewer must provide immediate notice of the review to the complainant and to us. Within 10 business days, the enrollee and HealthPartners must provide the reviewer with any information they wish to be considered. The enrollee (who may be assisted or represented by a person of their choice) and us shall be given an opportunity to present our versions of the facts and arguments. Any aspect of the external review involving medical determinations must be performed by a health care professional with expertise in the medical issue being reviewed.
- An external review must be made as soon as possible, but no later than 40 days after receipt of the request for external review. Prompt written notice of the decision and the reasons for it must be sent to the enrollee, the Commissioner of Health or Commissioner of Commerce, and to us.
- The results of the external review are non-binding on the enrollee and binding on us. We may seek judicial review on grounds that the decision was arbitrary and capricious or involved an abuse of discretion.

CONDITIONS

RIGHTS OF REIMBURSEMENT AND SUBROGATION

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

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

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

COORDINATION OF BENEFITS

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

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

1. Applicability.

a. This coordination of benefits (COB) provision applies to this Contract when an enrollee or the enrollee's covered dependent has health care coverage under more than one plan. "Plan" and "This Plan" are defined below.

b. If this coordination of benefits provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:
   (1) shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but
   (2) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in paragraph 4. below.

2. Definitions.

a. **"Plan"** is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

   (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
   (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

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

b. **"This Plan"** is the part of this Contract that provides benefits for health care expenses.

c. **"Primary Plan/Secondary Plan"** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more of the plans and may be a Secondary Plan as to a different plan or plans.

d. **"Allowable Expense"** is a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

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

3. Order Of Benefit Determination Rules.

a. **General**. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of another plan, unless:

(1) the other plan has rules coordinating its benefits with those of This Plan; and
(2) both those rules and This Plan's rules, in subparagraph b. below, require that This Plan's benefits be determined before those of the other plan.

b. **Rules**. This Plan determines its order of benefits using the first of the following rules which applies:

(1) Nondependent/Dependent. The benefits of the plan which cover the person as an enrollee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which cover the person as a dependent.

(2) Dependent Child/Parents not Separated or Divorced. Except as stated in subparagraph b., (3.) below, when This Plan and another plan cover the same child as a dependent of different persons, called "parents":

(a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
(b) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described in "(a.)" immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) first, the plan of the parent with custody of the child;
(b) then, the plan of the spouse of the parent with the custody of the child; and
(c) finally, the plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for health care expenses of the child, the plans covering follow the order of benefit determination rules outlined in subparagraph b., 2.

(5) Active/Inactive Enrollee. The benefits of a plan which covers a person as an enrollee who is neither laid off nor retired (or as that enrollee's dependent) are determined before those of a plan which cover that person as a laid off or retired enrollee (or as that enrollee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(6) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an enrollee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

4. Effect On The Benefits Of This Plan.

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

b. **Reduction in This Plan's Benefits**. The benefits of This Plan will be reduced by the benefits that would be payable for the Allowable Expenses under the other plans, whether or not 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 a member is legally entitled and for which facilities are reasonably available for military service-connected conditions or disabilities. Subject to our rights in part A. "Rights of Reimbursement and Subrogation" above, we will provide medically necessary services upon request and only pay expenses incurred for medical treatment otherwise covered by this plan if the no-fault insurer, employer, or national or state government or its agencies refuse to pay said expenses. You must cooperate with our program to bill allowable no-fault and workers' compensation claims to the appropriate insurer(s).

MEDICARE AND THIS CONTRACT

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

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

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

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

EFFECTIVE DATE AND ELIGIBILITY

EFFECTIVE DATE

Open Enrollment Period. If you enroll for coverage during the open enrollment period (November 1, 2021 through December 24, 2021), your coverage will be effective on January 1, 2022.

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 a case of an individual gaining access to a new Qualified Health Plan due to a permanent move AND you had qualifying health coverage for at least one day in the 60 days before your move, if the plan selection is made on or before the move, coverage is effective on the first of the month following the move;
5. For all other special enrollment period events listed under B. Eligibility below, 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 Contract, except as specified below for newborn and newly adopted children.

Open Enrollment Period. The open enrollment period begins on November 1, 2021 and extends through December 24, 2021. The annual open enrollment period and the date you have to enroll yourself and any eligible dependents as 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:

A. You must enroll yourself and any eligible dependents within 30 days of any of the events under this item A:

- 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.

B. You must enroll yourself and any eligible dependents within 60 days of any of the events under this item B:

- 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, 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 US.
- 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 contract.
- 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 new Qualified Health Plans offered through the Marketplace because of a permanent move AND you had qualifying health coverage for at least one day in the 60 days before your move, you may enroll anytime during the period starting 60 days prior to and ending 60 days following the date of your 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 and Human 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 annual open enrollment or a special enrollment period, you must wait until the next annual open enrollment or special enrollment period to enroll yourself and any eligible dependents.

Newborn Enrollment. Newborn infants (including a newborn grandchild of a covered grandparent) and a newly adopted child, may be covered regardless of when notice is received by us. However, we must receive required payments, if any, from the date of eligibility for a newborn infant (including a newborn grandchild of a covered grandparent) and a newly adopted child, before benefits will be paid. You must notify us immediately of any change in eligibility of an enrolled dependent.

CHANGES IN COVERAGE

All changes to this Contract must be approved by us. No agent can legally change this Contract 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 terminate this Contract at any time for you and your enrolled dependents. Coverage for you and your enrolled dependents terminates on the date specified by you, provided that you have given 14 days advance notice of termination. If you do not give 14 days advance notice of termination, coverage under this Contract will terminate 14 days following your request for termination.

INVOLUNTARY TERMINATION

We may terminate your coverage under this Contract 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 Contract's definition of eligible dependent, coverage for that dependent terminates the last day of the month in which the dependent's eligibility ceases.
- 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.

In the case of a dependent child who is losing coverage because of attainment of limiting age of 26, we will send a notice of termination to the members last known address at least 60 days before the termination date.

To the extent that a termination would be considered a rescission under state or federal law, we are required to give you 30 days advance notice of termination.

TERMINATION FOR CAUSE

1. The premium payment is due on or before the month during which coverage is provided. There is a 31-day grace period during which to pay the required payment. Coverage under this Contract will continue in effect during the grace period. If no payment is received within the 31-day grace period, coverage terminates retroactive to the paid through date. We are not obligated to accept any payments after the end of the grace period. We will bill you for your pre-payment on a monthly cycle.

   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 in 30 days 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 30-day period in the initial termination letter. You will be responsible for payment of any services provided after the date of termination.

2. In the event of misstatements made by the applicant in the application for coverage under this plan, no misstatement, except fraudulent misstatements, shall be used to void this Contract or deny a claim for benefits covered under this Contract for loss incurred or disability commencing after the expiration of the two year period beginning from the issue date of this Contract.

CLAIMS PROVISIONS

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

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

Send any claims to:

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

Proof of Loss: You must submit an itemized bill which documents the date and type of service, provider name and charges for covered services. Bills must be submitted within 90 days after the date services were first received. Where this section provides for payments contingent upon a period of confinement, these 90 days shall begin at the end of the period for which we are liable. If you do not furnish proof within 90 days as required, benefits shall still be paid for that loss if (1) it was not reasonably possible to give proof within those 90 days, and (2) proof is furnished as soon as reasonably possible. Any bills for covered services must be submitted to the plan within 15 months of incurring the charges. Any bill received at 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.

Information. When you seek coverage for goods or services under this Plan, you grant us the right to collect and review any claims, eligibility, coordination of benefits, rights of subrogation or medical or dental information necessary to make proper determination of coverage under this Plan. In the event you fail to cooperate with or execute any documents necessary for our review, we reserve the right to refuse or grant coverage for claims for which we have incomplete documentation.