HealthPartners Insurance Company

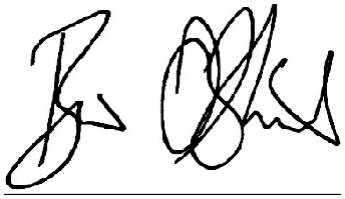
Group Certificate

HealthPartners Insurance Company North Dakota

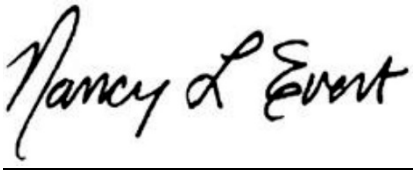
Small Employer Plan

MGC-900.0-ND-SE
(MEB-22)

HEALTHPARTNERS INSURANCE COMPANY



Brian O'Shields
President



Nancy L. Evert
Secretary

Group Insurance Certificate
Medical Expense Benefits

MGC-900.0-ND-SE
(MEB-22)

[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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Benefits Chart

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MISSION

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

ABOUT HEALTHPARTNERS INSURANCE COMPANY and HEALTHPARTNERS

HealthPartners Insurance Company. HealthPartners Insurance Company is the insurance company underwriting the benefits described in this Certificate. HealthPartners Insurance Company is a part of the HealthPartners family of related organizations. When used in this Certificate, "we", "us" or "our" has the same meaning as "HealthPartners Insurance Company".

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

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

IMPORTANT CONSUMER INFORMATION

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

TERMS AND CONDITIONS OF USE OF THIS CERTIFICATE

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

INTRODUCTION TO THE GROUP CERTIFICATE

GROUP CERTIFICATE

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

IDENTIFICATION CARD

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

ASSIGNMENT OF BENEFITS

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

ENROLLMENT PAYMENTS

This Certificate is conditioned on our regular receipt of enrollees' enrollment payments. The enrollment payments are made through the enrollee's group health plan sponsor, unless we have agreed to another payment method. Enrollment payments are based upon the certificate type and the number and status of any dependents enrolled with the enrollee.

Please refer to the most recent enrollment material for information regarding contributions to your plan which is hereby incorporated by this reference.

BENEFITS

This Certificate provides Benefits underwritten by HealthPartners Insurance Company, when you seek medical and dental services.

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

When you access certain Network Benefits, the benefits may be applied toward your maximum benefit limits under Non-Network Benefits. When you access certain Non-Network benefits, the benefits may be applied toward your maximum benefit limits under the Network Benefits. See the Benefits Chart to determine which benefit limits apply to Network Benefits, and/or Non-Network Benefits. The limits are described following the benefit levels for these services.

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

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

BENEFITS CHART

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

AMENDMENTS TO THIS CERTIFICATE

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

GROUP POLICY

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

CONFLICT WITH EXISTING LAW

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

HOW TO USE THE NETWORK

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

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

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

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

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

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

Access to Covered Services. If covered serves are not available through a network provider, covered services from a non-network provider will be reimbursed the same as a network provider.

ABOUT THE NETWORK

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

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 Certificate. 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.
- All services for the purpose of weight loss must be provided by a designated physician. Your physician will obtain or verify prior authorization for these services with HealthPartners, as needed.
- Multidisciplinary pain management must be provided at designated facilities. Your physician or facility will obtain or verify authorization for these services from HealthPartners, as needed.
- For Specialty Drugs that are 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.

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

Conditions that qualify for this benefit are:

- an acute condition;
- a life-threatening mental or physical illness;
- pregnancy 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 benefits will not be available or may be discontinued if the provider is terminated from the network for misconduct.

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

Prior Authorization for Services

Your physician may be required to obtain prior authorization for certain services. Your physician will coordinate the authorization process for any services which must first be authorized. You may call the Member Services Department or log on to your "*my*HealthPartners" account at healthpartners.com for a list of which services require your physician to obtain prior authorization.

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

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

When an authorization for a service is required, we will make an initial determination within 14 calendar days, so long as all information reasonably needed to make the decision has been provided. This time period may be extended for an additional 14 calendar days. If we request additional information, you have up to 45 days to provide the information requested. If the additional information is not received within 45 days, a coverage determination will be made based on the information available at the time of the review.

When an authorization for an urgent service is required, we will make an initial determination within 72 hours, so long as all information reasonably needed to make a decision has been provided. In the event that you have not provided all information necessary to make a decision, you will be notified of such failure within 24 hours. You will then be given 48 hours to provide the requested information. You will be notified of the benefit determination within 48 hours after the earlier of our receipt of the complete information or the end of the time granted to you to provide the specified additional information.

If the determination is made to approve the service, we will notify your health care provider by telephone, and may send written verification.

If the initial determination is made not to approve the service, we will notify your health care provider and hospital, if appropriate, by telephone within one working day of the determination, and we will send written verification with details of the denial. If you want to request an expedited review, or have received a denial of an authorization and want to appeal that decision, you have a right to do so. If your complaint is not resolved to your satisfaction in the internal complaint and appeal process, you may request an external review under certain circumstances. Refer to the information regarding Appeals Involving Medical Necessity Determinations in "Disputes and Complaints" for a description of how to proceed.

ACCESS TO RECORDS AND CONFIDENTIALITY

We comply with the state and federal laws governing the confidentiality and use of protected health information and medical or dental records. When your provider releases health information to us according to state law, we can use your protected health information when necessary, for certain health care operations, including: claims processing, including claims we make for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, case management, care coordination and utilization management, disease management, premium rating, claims experience reporting to your employer or other health plan sponsor; (only upon certification by your employer or plan sponsor of the compliance of plan documents with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")), the evaluation of potential or actual claims against us, auditing and legal services, and other access and use without further authorization if required by another law. When you enrolled for coverage, you authorized our access to use your records as described in this paragraph, and this authorization remains in effect unless it is revoked.

DEFINITIONS OF TERMS USED

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

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

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

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

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

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

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

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

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

Eligible Dependents. These are the persons shown below. Under this Certificate, a person who is considered an enrollee is not qualified as an eligible dependent. A person who is no longer an eligible dependent (as defined below) on an enrollee's Certificate may qualify for continuation of coverage within the group as provided in the "Continuation of Group Coverage" section of this Certificate.

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

2. **Child.** This is an enrollee's (a) natural or legally adopted child (effective from the date of 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) dependent of a dependent; or (e) stepchild of the enrollee (that is, the child of the enrollee's spouse). In each case the child must be either under 26 years of age or a disabled dependent, as described below.

   *(A description of the procedures governing qualified medical child support order determination can be obtained, without charge, from us.)

3. **Disabled Dependent.** This is an enrollee's dependent as defined above 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.

Enrollee. This is a person who is eligible through the group health plan sponsor's Group Policy, applies and is accepted by us for coverage under this Certificate.

Enrollment Date. This is the first day of coverage under this Certificate, or the first day of the waiting period, if earlier.

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

Group Health Plan Sponsor. This is the purchaser of this Certificate's group medical coverage, which covers the enrollee and any eligible dependents.

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

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

Home Hospice Program. This is a coordinated program of home-based, supportive and palliative care, for terminally ill patients and their families, to assist with the advanced stages of an incurable disease or condition. The services provided are comfort care and are not intended to cure the disease or medical condition, or to prolong life, in accordance with an approved home hospice treatment plan.

Hospital. This is a licensed facility, lawfully providing medical services in accordance with governmental licensing privileges and limitations, and which is recognized as an appropriate facility by us. A hospital is not a nursing home, or convalescent facility.

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

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

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

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

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

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

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

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

Medically Necessary Care. This is health care services and prescription drug use that are appropriate in terms of type, frequency, level, setting and duration to your diagnosis or condition, diagnostic testing and preventive services. Medically necessary care, as determined by us must be:

- Appropriate for the symptoms, diagnosis or treatment of your medical condition;
- Consistent with evidence-based standards of medical practice where applicable;
- Not primarily for your convenience or that of your family, your physician, or any other person; and
- The most appropriate and cost-effective level of medical service, prescription drugs or supplies that can be safely provided. When applied to inpatient care, it further means that the medical symptoms or conditions require that the medical services or supplies cannot be safely provided in a lower level of care setting.

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

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

Mental Health Professional. This is a psychiatrist, psychologist, or mental health therapist licensed for independent practice, lawfully performing a mental health or substance use disorder service in accordance with governmental licensing privileges and limitations, who renders mental health or substance use disorder services, as covered in this Certificate. For inpatient services, these mental health professionals must be working under the order of a physician.

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

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

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

Reconstructive Surgery. This is limited to reconstructive surgery, incidental to or following surgery, resulting from injury or illness of the involved part, or to correct a congenital disease or anomaly resulting in functional defect in a dependent child. A functional defect is one that interferes with your ability to perform activities of daily living.

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

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

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

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

SERVICES NOT COVERED

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

1. Treatment, procedures or services or drugs which are not medically or dentally necessary and/or which are primarily educational in nature or for your vocation, comfort, convenience, appearance, or recreation, including skills training.
2. Procedures, technologies, treatments, facilities, equipment, drugs and devices which are considered investigative, or otherwise not clinically accepted medical or dental services. We consider the following transplants to be investigative and do not cover them: surgical implantation of mechanical devices functioning as a permanent substitute for a human organ except as specified elsewhere in this Certificate, non-human organ implants and/or transplants and other transplants not specifically listed in this Certificate. While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered.
3. Rest and respite services and custodial care, except as respite services are specifically described in the Benefits Chart under the subsection "Home Hospice Services". This includes all services, medical equipment and drugs provided for such care.
4. 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.

5. Foster care, adult foster care and any type of family child care provided or arranged by the local state or county.
6. Services associated with non-covered services, including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies. This exclusion does not apply to medically necessary complications related to an excluded service if they would otherwise be covered under this Certificate.
7. Services from non-medically or non-dentally licensed facilities or providers and services outside the scope of practice or license of the individual or facility providing the service.
8. Cosmetic surgery, cosmetic services and treatments, including drugs, primarily for the improvement of your appearance or self-esteem, including, but not limited to, augmentation procedures, reduction procedures and scar revision. This exclusion does not apply to services for reconstructive surgery.
9. Dental treatment, procedures or services not listed in the Benefits Chart.
10. 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.
11. 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.
12. Court ordered treatment.
13. Infertility/fertility treatment, including but not limited to, office visits, laboratory services, diagnostic imaging services and fertility drugs, reversal of sterilization; and sperm, ova or embryo acquisition, retrieval or storage; however, we do cover office visits and consultations to diagnose infertility.
14. Services related to the establishment of surrogate pregnancy and fees for a surrogate. However, pregnancy and maternity services are covered for an insured under this Certificate including a surrogate pregnancy.
15. Acupuncture.
16. Routine foot care, unless the services meet our criteria for medically necessary care.
17. Vision correction surgeries such as keratotomy and keratorefractive surgeries, including LASIK surgery, except as specifically described in the medical coverage criteria.
18. Eyeglasses, contact lenses and their fitting, measurement and adjustment,except as specifically described in the Benefits Chart. This exclusion does not apply to pediatric eyewear.
19. Communication aids or devices: equipment to create, replace or augment communication abilities including but not limited to speech processors, receivers, communication boards, or computer or electronic assisted communication.
20. Hearing aids (implantable and external, including osseointegrated or bone anchored) and their fitting, except as specifically described in the Benefits Chart. This exclusion does not apply to cochlear implants.
21. Medical Food. Enteral feedings, unless they are the sole source of nutrition used to treat a life-threatening condition, nutritional supplements, over-the-counter electrolyte supplements and infant formula. This exclusion does not apply to special dietary treatment for Phenylketonuria (PKU) if it meets our medical coverage criteria or oral amino acid based elemental formula or other items if they meet our medical coverage criteria.
22. Services provided by a family member of the enrollee, or a resident in the enrollee's home.
23. Religious counseling; marital/relationship counseling and sex therapy.
24. Private duty nursing services.
25. Services that are provided to you, if you also have other primary insurance coverage for those services and you do not provide us the necessary information to pursue Coordination of Benefits, as required under this Certificate.
26. For Non-Network benefits, the portion of a billed charge for an otherwise covered service by a provider, which is in excess of the usual and customary charges. We also do not cover charges or a portion of a charge which is either a duplicate charge for a service or charges for a duplicate service.
27. Charges for services (a) for which a charge would not have been made in the absence of insurance or health plan coverage, or (b) which you are not obligated to pay, and (c) from providers who waive copayment, deductible and coinsurance payments by the insured, except in cases of undue financial hardship.
28. Provider and/or insured travel and lodging incidental to travel, regardless if it is recommended by a physician, except as specified in the Transplant Travel Benefit section of the Benefits Chart.
29. Health club memberships.
30. Elective abortions, except in the case of rape or incest, or situations where the life of the mother would be endangered if the fetus is carried to full term.

31. Orthognathic treatment or procedures and all related services, except for procedures considered reconstructive surgery, or when required to directly treat a medical condition.
32. Massage therapy for the purpose of comfort or convenience of the insured.
33. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
34. Autopsies, unless we request an autopsy to resolve a claim dispute.
35. For Network Benefits, charges incurred for transplants provided by a facility that is not a designated transplant center 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 restoration, or (5) received beyond twenty-four months from the date of injury.
37. All drugs used for the treatment of sexual dysfunction.
38. Nonprescription (over the counter) drugs or medications, including, but not limited to, vitamins, supplements, homeopathic remedies, and non-FDA approved drugs, unless listed on the formulary drug list 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 the Benefits Chart. This exclusion does not include over-the-counter contraceptives for women as allowed under the Affordable Care Act when the insured obtains a prescription for the item. In addition, if the insured obtains a prescription, this exclusion does not include aspirin to prevent cardiovascular disease for men and women of certain ages; folic acid supplements for women who may become pregnant; fluoride chemoprevention supplements for children without fluoride in their water source; and iron supplements for children ages 6-12 months who are at risk for anemia.
39. Charges for sales tax.
40. Charges for elective home births.
41. Professional services associated with substance use disorder interventions. A "substance use disorder intervention" is a gathering of family and/or friends to encourage a person covered under this Certificate to seek substance use disorder treatment.
42. Services provided by naturopathic providers.
43. Oral surgery to remove wisdom teeth, except as covered for an individual to the end of the month in which they turn 19 as specified in the pediatric dental amendment.
45. Commercial weight loss programs and exercise programs.
46. Treatment, procedures, or services or drugs which are provided when you are not covered under this Certificate.
48. Non-medical administrative fees and charges including but not limited to medical record preparation charges, appointment cancellation fees, after hours appointment charges, and interest charges.
50. Medical cannabis.
51. Drugs on the Excluded Drug List. The Excluded Drug List includes select drugs within a therapy class that are not eligible for coverage. This includes drugs that may be excluded for certain indications. The Excluded Drug List is available at healthpartners.com.
52. Drugs that are newly approved by the FDA until they are reviewed and approved by HealthPartners Pharmacy and Therapeutics Committee.
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.

DISPUTES AND COMPLAINTS

DETERMINATION OF COVERAGE

Eligible services are covered only when medically or dentally necessary for the proper treatment of an insured. Our medical or dental directors, or their designees, make coverage determinations of medical or dental necessity, restrictions on access and appropriateness of treatment, and they make final authorization for covered services. Coverage determinations are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. Frequency limits, deductibles, copayments or coinsurance, or other maximums or limits for certain covered pediatric dental services may not apply for certain medical conditions if you meet specific coverage criteria set by our dental directors. Covered prescription drugs are based on requirements established by the HealthPartners Pharmacy and Therapeutics Committee, and are subject to periodic review and modification.

COMPLAINTS

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

2. **Definitions:**

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

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

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

   Authorized Representative. This is anyone acting on your behalf to issue a complaint or grievance. You may designate an authorized representative by sending an appropriately-worded authorization permitting us to disclose your personal health information to your authorized representative. We will provide you with an authorization form to complete, upon request. The purpose of the authorization is to ensure that we have your permission to disclose your personal health information to a third party. Unless otherwise permitted by applicable law, if a third party issues a complaint or grievance and we do not have such authorization from you, we will investigate the issue and respond to you directly with the outcome.

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

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

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

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

3. **Complaint and Appeal Process**

   a. **Complaints:**

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

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

At any time, the complainant may also file a complaint with the North Dakota Insurance Department, either in writing to North Dakota Insurance Department, 600 East Boulevard Avenue, Bismarck, ND 58505-0320 or by calling 800-247-0560.

b. Appeals Process:

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

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

HealthPartners Insurance Company
Member Services Department
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 1-844-732-3545

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

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

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

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

Appeals Involving Medical Necessity Determinations.

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

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

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

All Other Appeals.

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

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

All notifications described above will comply with applicable law.

(2) Second Level Appeal. If you file a first level appeal 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 the denial, submit a written request for a second level appeal, including any relevant documents, and submit issues, comments and additional information as appropriate to:

HealthPartners Insurance Company
Member Services Department
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 1-844-732-3545

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. Independent Review Procedures:

a. If we have made an Adverse Determination (defined above), you may request independent review of our decision if you request an external review within four months of the adverse determination.

- To initiate an external review process, you or your representative may submit a written request for an independent review to us.
- Upon receipt of the request for independent review, the Independent Review Organization must provide immediate notice of the review to the complainant and to us. Within 10 business days, the enrollee and HealthPartners Insurance Company must provide the reviewer with any information they wish to be considered. The enrollee (who may be assisted or represented by a person of their choice) and HealthPartners Insurance Company shall be given an opportunity to present their version of the facts and arguments. Any aspect of the external review involving medical determinations must be performed by a health care professional with expertise in the medical issue being reviewed.
- An independent review must be made as soon as possible, but no later than 45 days after receipt of the request for independent review. Prompt written notice of the decision and the reasons for it must be sent to the enrollee and to us.

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

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

HealthPartners Insurance Company
Member Services Department
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 1-844-732-3545

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

c. The IRO will notify you and us of its determination within 45 calendar days (or within 72 hours of its receipt of all needed information, if the independent review is expedited).

d. The determination of the IRO is binding on you and on us. However, decisions regarding rescissions are not binding on the Insured.

5. **North Dakota Insurance Department:** At any time, you may also file a complaint with North Dakota Insurance Department by calling 1-800-247-0560 to request a complaint form.

CONDITIONS

RIGHTS OF REIMBURSEMENT AND SUBROGATION

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

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

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

COORDINATION OF BENEFITS

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

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

1. **Applicability.**

   This coordination of benefits (COB) provision applies when a person has health care coverage under more than one plan. "Plan" is defined below.

   The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

2. Definitions.

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

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

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

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

c. "**Primary Plan/Secondary Plan"** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more of the plans and may be a Secondary Plan as to a different plan or plans.

d. "Allowable Expense" is a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a primary plan because an insured does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

If a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in section 223(c) (2) (C) of the Internal Revenue Code of 1986.

An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.

Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

(1) If a person is confined in a private hospital room, 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 one of the plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that calculates its benefits for services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

(5) The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drugs, or hearing aids. A plan that limits the application of coordination of benefits to certain coverages or benefits may limit the definition of allowable expense in its contract to expenses that are similar to the expenses that it provides. When coordination of benefits is restricted to specific coverages or benefits in a contract, the definition of allowable expense shall include similar expenses to which coordination of benefits applies.

(6) When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

(7) The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan:

a. Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services; or

b. Because the covered person has a lower benefit because the covered person did not use a preferred provider.

e. "Birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.

f. "Claim" means a request that benefits of a plan be provided or paid. The benefits claims may be in the form of:

(1) Services, including supplies;

(2) Payment for all or a portion of the expenses incurred;

(3) A combination of subdivisions a and b; or

(4) An indemnification.

g. "Closed panel plan" means a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

h. "Consolidated Omnibus Budget Reconciliation Act of 1985" or **"COBRA"** means coverage provided under a right of continuation pursuant to federal law.

i. "Coordination of benefits" or **"COB"** means a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

j. "Custodial parent" means:

- The parent awarded custody of a child by a court decree; or
- In the absence of a court decree, the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

k. "Group-type contract" means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage.

"**Group-type contract**" does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

l. **"High-deductible health plan"** has the meaning given the term under section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

m. **"Hospital-indemnity benefits"** means benefits not related to expenses incurred.

"**Hospital-Indemnity benefits**" does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

n. **"Plan"** means a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no coordination of benefits among the separate parts of the plan.

If a plan coordinates benefits, its contract shall state the types of coverage that will be considered in applying the coordination of benefits provision of that contract. Whether the contract uses the term "plan" or some other term such as "program", the contractual definition may be no broader than the definition of "plan" in this subsection.

Plan includes:

(1) Group and non-group insurance contracts and subscriber contracts;

(2) Uninsured arrangements of group or group-type coverage;

(3) Group and non-group coverage through closed panel plans;

(4) Group-type contracts;

(5) The medical component of long-term care contracts, such as skilled nursing care;

(6) The medical benefits coverage in automobile "no-fault" and traditional automobile "fault" type contracts subject to the provisions of the North Dakota no-fault coordination of benefits provisions as set forth in subsection 3 of section 26.1-41-13; and

(7) Medicare or other governmental benefits, as permitted by law, except as provided in paragraph 8 of subdivision d. That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

Plan does not include:

(1) Hospital indemnity coverage or other fixed indemnity coverage;

(2) Accidental-only coverage;

(3) Specified disease or specified accident coverage;

(4) Limited benefit health coverage;

(5) School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four hour basis or on a "to and from school" basis;

(6) Benefits provided in long-term care insurance policies for nonmedical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

(7) Medicare supplement policies;

(8) A state plan under Medicaid; or

(9) A governmental plan, which by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

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

o. **"Policyholder"** means the primary insured named in a non-group insurance policy.

p. **"Primary plan"** means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is primary plan if:

- The plan either has no order of benefit determination rules, or its rules differ from those permitted by this section; or
- All plans that cover the person use the order of benefit determination rules required by the section, and under those rules the plan determines its benefits first.

q. **"Secondary plan"** means a plan that is not a primary plan.

r. **"This Plan"** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.

When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits its pays so that all plan benefits do not exceed 100% of the total allowable expense.

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

3. Order of Benefit Determination Rules.

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

(1) the other plan has rules coordinating its benefits with those of This Plan; and

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

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

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

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

(a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

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

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

(a) first, the plan of the parent with custody of the child;

(b) then, the plan of the spouse of the parent with the custody of the child; and

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

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

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

(6) COBRA or state continuation coverage.

If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law has coverage under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

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.

This rule does not apply if the rule in subdivision a can determine the order of benefits.

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

4. Effect on The Benefits of This Plan.

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

b. Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

(1) the benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

(2) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

(3) This Plan shall credit to its deductible(s) any amounts it would credit to its deductible(s) in the absence of the other plans.

5. Right to Receive And Release Needed Information. Certain facts are needed to apply these COB rules. We have the right to decide which facts we need. Consistent with applicable state and federal law, we may get needed facts from or give them to any other organization or person, without your further approval or consent. Unless applicable federal or state law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under This Plan must give us any facts we need to pay the claim.

6. **Facility of Payment.** A payment made under another plan may include an amount which should have been paid under This Plan. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

7. **Right of Recovery.** If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of:

   a. the persons it has paid or for whom it has paid;

   b. insurance companies; or

   c. other organizations.

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

   The benefits provided by this plan do not apply to injury or disease covered by no-fault insurance, employers liability laws (including workers' compensation), and care available or required to be furnished by or through national or state governments or their agencies including care to which you are legally entitled and for which facilities are reasonably available for military service-connected conditions or disabilities. Subject to our rights 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 worker's compensation claims to the appropriate insurer(s).

   Coordination of benefits differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

   If the plans cannot agree on the order of benefits within thirty calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

MEDICARE AND THIS CERTIFICATE

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

Medicare is the primary payer for persons with end stage renal disease, after the 30 month period following the earlier of (1) the month in which the insured begins a regular course of renal dialysis, or (2) the first of the month in which the insured became entitled to Medicare, if the insured received a kidney transplant without first beginning dialysis. This is regardless of the size of the employer. Medicare is primary payer for retirees who are age 65 or over. Also, Medicare is a primary payer for insureds under age 65, who are covered by Medicare because of disability (other than end stage renal disease), when (1) the employer employs fewer than 100 employees and the insured or their spouse or parent has group health plan coverage due to current employment, or (2) the insured or their spouse or parent has coverage not due to current employment, regardless of the number of employees of the employer.

Medicare is secondary payer for Medicare enrollees who: (1) are active employees and (2) are covered by Medicare because they have reached age 65 when there are 20 or more employees in the group. The Medicare secondary payer rules change from time to time and the most recent rule will be applied.

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

We also reserve the right to reduce benefits for any medical expenses covered under this Certificate by the amount of any benefits available for such expenses under Medicare. This will be done before the benefits under this Certificate are calculated.

Charges for services used to satisfy an insured's Medicare Part B deductible will be applied under this Certificate in the order received by us. Two or more charges for services received at the same time will be applied starting with the largest first.

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

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

EFFECTIVE DATE AND ELIGIBILITY

EFFECTIVE DATE

Your coverage begins on the effective date contained in the information which accompanies your initial identification card. Your coverage is contingent upon fulfillment of the eligibility rules contained in the Group Policy.

ELIGIBILITY

You must make written application to enroll yourself and any eligible dependents, and such application must be received by us within 31 days of the date you first become eligible, in order for coverage under this Certificate to be effective on the eligibility date. Similarly, you must make written application to enroll a newly acquired dependent, and we must receive such written application and receive any required payments, if any, within 31 days of when you first acquire the dependent (e.g., through marriage), in order for coverage under this Certificate to be effective on the eligibility date.

Late Enrollment. If you do not enroll yourself or any eligible dependents within 31 days of the date that you or your dependents first become eligible, you may enroll yourself and any eligible dependents during the annual open enrollment period, or a special enrollment period.

1. **Special Enrollment Period.** If you are eligible, but not enrolled for coverage under this Certificate, or your dependent, if the dependent is eligible but not enrolled for coverage under this Certificate, you or your dependent may enroll for coverage under the terms of this Certificate if all of the following conditions are met:

    a. you or your dependent were covered under a group health plan or had health insurance coverage at the time coverage was previously offered to you or your dependent;

    b. you stated in writing at the time of initial eligibility that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the group health plan sponsor required this and provided you with notice of this requirement and the consequences of it;

    c. you or your dependent's coverage described in a. above was:

        (1) under a COBRA continuation provision and that coverage was exhausted; or

        (2) not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, cessation of dependent status or reduction in the number of hours of employment; a situation in which the individual incurs a claim that would meet or exceed a lifetime limit on all benefits; a situation in which coverage is no longer offered to the class of similarly situated individuals that includes the individual; a situation in which an individual loses coverage through a health maintenance organization or other arrangement because that individual no longer resides, lives or works in the health maintenance organization's service area or a situation in which the individual's benefit option is terminated) or the employer contributions toward coverage were terminated; and

    d. you requested this enrollment not later than 30 days after the date of exhaustion of coverage described in c. (1) above, or one of the events listed in c. (2) above.

2. Dependents may enroll if: (a) a group health plan makes coverage available with respect to your dependent; (b) you are covered under this Certificate (or have met any waiting period applicable to becoming covered under this Certificate and are eligible to be enrolled under this Certificate but for a failure to enroll during a previous enrollment period); and (c) a person becomes your dependent through marriage, birth, or adoption or placement for adoption. This Certificate shall provide for a dependent special enrollment period during which the person may be enrolled under this Certificate as your dependent and in the case of the birth or adoption of a child, your spouse may be enrolled as your dependent if otherwise eligible for coverage. You may also enroll at this time. A dependent special enrollment period shall be a period of not less than 30 days and shall begin on the later of:

a. the date dependent coverage is made available; or

b. the date of the marriage, birth, or adoption or placement for adoption described in (c) in the paragraph above.

If an insured seeks to enroll a dependent during the first 30 days of a dependent special enrollment period, the coverage of the dependent shall become effective:

a. in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

b. in the case of a dependent's birth, as of the date of birth;

c. in the case of a dependent's adoption or placement for adoption, the date of adoption or placement for adoption; or

d. in the case of a child support order or other court order; as of the date specified in the order.

3. You may also enroll yourself and any eligible dependents if you enroll within 30 days of any of the events under this item 3.:

a. If you or your dependents lose group coverage because of termination of employment (except for gross misconduct) or reduction in hours.

b. If you or your dependents lose group coverage because of the death of the enrollee.

c. If you or your dependents lose group coverage because of divorce or legal separation.

d. If your dependent loses group coverage because of loss of eligibility as a dependent child.

e. If you or your dependents lose group coverage because the group enrollee's initial enrollment for Medicare.

f. For a retired enrollee, spouse and other dependents, if you lose group coverage because of the bankruptcy filing by a former employer, under Title XI, United States Code, on or after July 1, 1986.

Special Rules Relating to Medicaid and the Children's Health Insurance Program ("CHIP"). In general, if you are eligible but not enrolled for coverage under the terms of this plan (or if your dependent is eligible but not enrolled for coverage under such terms), you may enroll for coverage under the terms of this plan if either of the following conditions is met:

a. Termination of Medicaid or CHIP Coverage. You or your dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a state child health plan under title XXI of such Act and coverage of you or your dependent under such plan is terminated as a result of loss of eligibility for such coverage and you request coverage under this plan not later than 60 days after the date you or your dependent lose coverage under that plan; or

b. Eligibility for Employment Assistance under Medicaid or CHIP. You or your dependent becomes eligible for assistance, with respect to coverage under this plan, under such Medicaid plan or state child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if you request coverage under this plan not later than 60 days after the date you or your dependent becomes eligible for such assistance.

CHANGES IN COVERAGE

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

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

CONTINUATION OF GROUP COVERAGE

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

CONTINUATION OF GROUP COVERAGE

1. **Qualifying Events.** Coverage under this Certificate may be continued by an enrollee, spouse and other dependents, enrolled at the time coverage would otherwise end, or a child born to or placed for adoption with the enrollee during the period of continuation coverage, as a result of one of the following qualifying events.
   a. Termination of employment (except for gross misconduct) of the enrollee, or reduction in hours resulting in a loss of group coverage.
   b. Death of the enrollee.
   c. Divorce or legal separation from the enrollee.
   d. Loss of eligibility as a dependent child.
   e. Initial enrollment of the enrollee for benefits under Title XVIII of the Social Security Act (Medicare).
   f. For a retired enrollee, spouse and other dependents, the bankruptcy filing by a former employer, under Title XI, United States Code, on or after July 1, 1986.
2. **Duration of Continuation Coverage.** The maximum period coverage can be continued depends on the qualifying event. It may be terminated earlier as shown below. The maximum period of continuation coverage starts on the day of the qualifying event.
   a. Maximum period.
   (1) Termination and reduced hours. The maximum period of continuation coverage is 18 months. If a second qualifying event, other than the employer's bankruptcy, occurs during the 18 months, the maximum period of continuation coverage is 36 months. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".
   (2) Disabled enrollee, spouse or dependent child. If the enrollee, spouse or other dependent is disabled under Title II or XVI of the Social Security Act, at any time during the first 60 days of continuation coverage, the 18-month maximum continuation period may be extended to 29 months. The disabled person must notify the group health plan sponsor within 60 days of the date of determination of disability, and within the initial 18-month continuation period. If a second qualifying event (other than bankruptcy) occurs during the extended 29-month period, the maximum period of continuation coverage is 36 months. See part B.
   (3) Bankruptcy. In the case of bankruptcy of a retired enrollee's former employer, the maximum period of continuation coverage is until the death of the retired enrollee. In the case of the surviving spouse or dependent children of the retired enrollee, the maximum period of continuation coverage is 36 months after the death of the retired enrollee.
   (4) Divorce or legal separation. The maximum period of coverage for a former spouse and covered dependents who lose coverage due to divorce or legal separation is 36 months.
   (5) Death of enrollee. The maximum period of coverage for a surviving spouse and covered dependents who lose coverage due to the death of the Covered Employee is 36 months.
   (6) Initial enrollment of the enrollee for benefits under Title XVIII of the Social Security Act (Medicare). If a spouse or dependent children lose coverage under this plan when the enrollee initially enrolls for benefits under Title XVIII of the Social Security Act, they may continue coverage under this plan for a maximum period of 36 months.
   (7) Other qualifying events. The maximum period of continuation coverage for all other qualifying events is 36 months.

b. Earlier Termination. Coverage terminates before the end of the maximum period if any of the following occurs.

(1) End of the plan. The group health plan sponsor terminates the agreement under which this coverage is offered to its enrollees.

(2) Failure to pay premium. The person receiving continuation coverage does not make the monthly payment within 30 days of the due date.

(3) Other group health coverage. The person receiving continuation coverage becomes covered under any other group health type coverage, not containing an exclusion or limitation for any pre-existing condition of the person. If the other group health coverage contains a pre-existing condition limitation, continuation coverage is extended until the pre-existing limitation is satisfied or coverage is otherwise terminated. A person will not be subject to earlier termination of continuation coverage on account of coverage under another group plan that existed prior to that person's first day of continuation coverage.

(4) Termination of extended coverage for disability. In case a person receives extended (29-month) continuation coverage due to disability at the time of termination or reduced hours, the extended coverage terminates at the beginning of the month 30 days after a final determination that the person is no longer disabled.

(5) Termination provisions of this Certificate. The person receiving continuation coverage whose coverage is subject to the termination clause under the "Termination" section of this Certificate.

3. Election of Continuation Coverage.

a. You have 60 days to elect continuation of group coverage. The 60-day period begins on the date your group coverage would otherwise terminate due to a qualifying event or the date on which written notice of your right of continued group coverage is mailed, whichever is later.

b. If you wish to continue group coverage as shown above, you must apply in writing to your group health plan sponsor (not us). You must also pay your first monthly payment within 45 days of the date you elected to continue group coverage. If your coverage was terminated because of the death of the enrollee, your initial payment is not due until 90 days after you receive notice of the continuation right. Thereafter, your monthly payments are due and payable at the beginning of each month for which coverage is to be continued.

c. You or your enrolled dependents must notify the group health plan sponsor within 60 days, when divorce, legal separation, change in status resulting in a loss of eligibility as a dependent would end coverage or a second qualifying event occurs. The 60 day period begins on the date of the divorce, legal separation, change in dependent status or second qualifying event.

d. You may be required to pay the entire cost of COBRA continuation coverage plus a 2% administrative fee for each enrollee and enrolled dependent. If you are a former spouse of the enrollee and the enrollee is enrolled for coverage that would cover a current spouse, your coverage is continued at no additional premium, until the enrollee cancels such coverage. If the enrollee cancels dependent coverage for their current spouse, you will then be required to pay continuation premium as described in the first sentence of this paragraph.

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

a. You must comply with the time limits for providing notices required in paragraph 3.c. above.

b. Your notice must be in writing and contain at least the following information:

(1) The names of the enrollee, covered spouse and other covered dependents;

(2) The qualifying event or disability; and

(3) The date on which the qualifying event (if any) occurred.

c. You must check with your employer for information regarding the person or entity that your notice should be sent to.

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

REPLACEMENT OF COVERAGE WHEN YOU ARE CONFINED

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

TERMINATION

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

1. The premium payment is due on or before the beginning of the month during which coverage is provided. There is a 31-day grace period during which to pay the required payment. Coverage under this Certificate will continue in effect during the grace period. If no payment is received by us within the 31-day grace period, coverage terminates, retroactive to the paid through date. We are not obligated to accept any payment after the end of the grace period.
2. When an enrollee ceases to be eligible under the terms of the Group Policy, coverage for the enrollee and all enrolled dependents terminates on the last day of the month in which the enrollee's eligibility ceases, unless group continuation is elected as described in "Continuation of Group Coverage" above.
3. When an enrolled dependent no longer meets this Certificate's definition of eligible dependent, coverage for that dependent terminates on the last day of the month in which the dependent's eligibility ceases, unless group continuation is elected as described in "Continuation of Group Coverage" above.
4. When the Certificate maximum eligibility period under the group continuation coverage described in "Continuation of Group Coverage" above expires for an enrollee or dependent.
5. When the Group Policy is terminated, either as requested by us or the health plan sponsor, in accordance with the terms of the Group Policy.
6. When the group health plan sponsor terminates participation under the Group Policy.
7. In the event of misstatements made by the applicant in the application for coverage under this plan, no misstatement, except fraudulent misstatements, shall be used to void this Certificate or deny a claim for benefits covered under this Certificate for loss incurred or disability commencing after the expiration of the two year period beginning from the issue date of this Certificate.

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

Extension of benefits due to total disability. If an insured is totally disabled on the date coverage is discontinued or replaced, coverage for the totally disabled person will continue as provided by North Dakota Administrative Code Chapter 45-08-02. Coverage will extend for up to 12 months. However, benefits are limited to medically necessary services and supplies to treat the disabling condition.

STANDARD PROVISIONS

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

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

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

CLAIMS PROVISIONS

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

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

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

Time of Payment of Claims. We will make payment promptly upon receipt of due written proof of loss. Benefits which are payable periodically during a period of continuing loss shall be payable on at least a monthly basis. We must pay, deny or request additional information for claims within 15 days of our receipt of the claim and will notify you of any remaining liability. If we do not pay or deny a clean claim within 15 days of our receipt of the claim, we must pay 1.5 percent interest per month or any part of a month.

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

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

If the insured is deceased at the time payment for claims is made, all payments for claims other than those paid directly to the provider of medical or dental services will be paid to the beneficiary, if none, to the estate of the insured.

Physical Examinations and Autopsy. In the event we require information from a physical examination or autopsy to properly resolve a claim dispute, we may request this information from you or your legal representative. Such examinations or autopsy shall be performed at our expense. Failure to submit the required information may result in denial of your claim.

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

STATEMENT OF ERISA RIGHTS

For group health plans that are subject to ERISA, federal law and regulations require that this "Statement of ERISA Rights" be included in this Group Certificate. This "Statement of ERISA Rights" is not applicable to group health plans that are not subject to ERISA. Your group health plan sponsor can tell you whether or not your plan is subject to ERISA. ERISA rights are in addition to any rights you may also have under state law; however, federal law may not invalidate, impair or supersede state law.

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

Receive Information About Your Plan and Benefits

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

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and, where applicable, copies of the latest annual report (Form 5500) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights. See the "Continuation of Group Coverage" section of this Group Certificate.

Prudent actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of non-privileged documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance With Your Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SPECIFIC INFORMATION ABOUT THE PLAN

The federal government requires that the following information be furnished for the Plan:

Name of the Plan:	See your employer's plan documents.
Address of the Plan:	See your employer's plan documents.
IRS Employer Identification Number:	See your employer's plan documents.
Plan Identification Number:	See your employer's plan documents.
Plan Year:	See your employer's plan documents.
Plan Fiscal Year Ends:	See your employer's plan documents.
Plan Administrator:	Your employer.
Agent for Service of Legal Process:	For this Group Certificate's benefits: HealthPartners Insurance Company For all other matters: your employer.
Named Fiduciary:	For this Group Certificate's benefits: HealthPartners Insurance Company For all other matters: your employer.
Funding:	This Group Certificate is fully insured under North Dakota law.
Network Providers:	HealthPartners Network
Contributions:	Employer and Employee. For more details, see your employer's enrollment materials.
Employment Waiting Period:	See your employer's plan documents.
Eligible Classes:	See your employer's plan documents.
Contact for Continuation of Coverage Notices:	See your employer's plan documents.