OFFICE OF THE ATTORNEY GENERAL
State of Minnesota
ST. PAUL, MN 55155

LORI SWANSON
ATTORNEY GENERAL

August 19, 2013

The Honorable Mike Rothman
Commissioner
Minnesota Department of Commerce
85 East Seventh Place, Suite 500
St. Paul, MN 55101

The Honorable Dr. Edward Ehlinger
Commissioner
Minnesota Department of Health
Orville L. Freeman Building
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0975

The Honorable Lucinda Jesson
Commissioner
Minnesota Department of Human Services
MNsure Board of Directors
Elmer L. Andersen Building
540 Cedar Street
P.O. Box 64998
St. Paul, MN 55164-0998

The Honorable Jim Schowalter
Commissioner
Minnesota Management and Budget
400 Centennial Building
658 Cedar Street
St. Paul, MN 55155

Re: Opinion Pursuant to 2013 Minn. Laws ch. 108, art. 12, § 107

Dear Commissioners Rothman, Jesson, Ehlinger, and Schowalter:

In the most recent legislative session, the Minnesota Department of Commerce was directed to request the United States Department of Health and Human Services ("HHS") to include insurance coverage for autism services in the benefit set for Minnesota beginning in 2016.[1] The Commerce Department was also directed to determine options for coverage of treatment of autism spectrum disorders.[2] The premise of these legislative directives appears to be that the Minnesota Legislature has not mandated coverage for such treatment. Nonetheless, the Legislature also directed this Office to issue an opinion on whether health plans are mandated to provide coverage for treatment of mental health-related illnesses and autism spectrum disorders.[3] This opinion letter is issued pursuant to this legislative directive.

LAW AND ANALYSIS

A "health plan" is a policy, certificate, or contract of accident and sickness insurance offered by an insurance company, a nonprofit health service plan corporation, a health maintenance organization, a fraternal benefit society, a joint self-insurance employee health plan, or a community integrated service network.[4] This opinion separately analyzes the coverage of autism spectrum disorder treatment and mental health treatment that is statutorily required to be

provided by fully-insured individual health plans, small group health plans, and fully-insured large employer health plans in Minnesota.

I. FULLY-INSURED INDIVIDUAL AND SMALL-GROUP HEALTH PLANS.

A. States Must Cover "Essential Health Benefits" Comparable To Those Covered In Their "Benchmark Plans."

In 2010, Congress enacted the Affordable Care Act ("ACA"). Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010), *as amended by* Health Care and Education Reconciliation Act of 2010 ("HCERA"), Pub. L. 111-152, 124 Stat. 1029 (2010). Under the ACA, fully-insured individual and small employer health plans that take effect beginning on or after January 1, 2014 must cover "essential health benefits," also referred to as "EHBs." ACA §§ 1201(4), 1251(a), (e), 1255, 1301(b)(1)(B), 10103(d)-(f). Under the ACA, a small employer health plan is generally one purchased by an employer with 100 or fewer employees, although the ACA allows states to define a small employer as 50 or fewer employees for plan years beginning before January 1, 2016. *Id.* § 1304(b)(1)-(3). Minnesota has defined a "small employer" as one with 50 or fewer employees. *See* 2013 Minn. Laws ch. 84, art. 1, § 47, art. 2, § 4, at 502-03, 537 (amending Minn. Stat. § 62L.02, subd. 26, and enacting Minn. Stat. § 62K.03, subd. 12).

Under the ACA, EHBs include ten categories of benefits, including benefits for "[m]ental health and substance use disorder services, including behavioral health treatment." *Id.* § 1302(b)(1)(E). HHS allowed each state to further define the benefits within each EHB category through the selection of a "benchmark plan." *Standards Related to Essential Health Benefits, Actuarial Value, & Accreditation*, 78 Fed. Reg. 12,834, 12,840-41 (Feb. 25, 2013). All individual and small employer health plans offered in each state must then provide coverage that is substantially equal to that in the benchmark plan in terms of covered benefits, limitations on coverage, and prescription-drug benefits. *Id.* at 12,867 (to be codified at 45 C.F.R. § 156.115(a)(1)). If a benchmark plan fails to provide coverage in an EHB category, the plan must be supplemented to provide coverage. *Id.* at 12,866 (to be codified at § 156.110(b)).

States had authority to select their own benchmark plan from either the largest plan by enrollment offered in the small-group market or by a health-maintenance organization or the largest plan offered to state and federal employees. *Id.* (to be codified at 45 C.F.R. § 156.100(a)). If a state failed to select a benchmark plan, the benchmark plan by default became the largest plan by enrollment in the state's small-group market. *Id.* (to be codified at § 156.100(c)).

B. Minnesota's Benchmark Plan Was Adopted By Default.

Approximately 24 states actively selected a benchmark plan and approximately 26 states allowed the default plan (i.e., the largest small employer health plan in the state) to become their benchmark plan.[5] Minnesota did not actively select a benchmark plan. As a result, HHS determined that Minnesota's benchmark plan defaulted to the HealthPartners Small Group Product (HealthPartners 500 25 Open Access PPO).[6] A copy of this policy—which is now Minnesota's benchmark plan—is attached as Exhibit 1. The Minnesota Department of Commerce approved the HealthPartners plan for issuance in Minnesota on April 27, 2011. Ex. 2.

C. Coverage For Mental Health Treatment Under Minnesota's Benchmark Plan.

As previously noted, EHBs must include coverage for "[m]ental health and substance use disorder services, including behavioral health treatment." ACA § 1302(b)(1)(E). Furthermore, effective May 25, 2013, all health plans in Minnesota must comply with all applicable requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), Pub. L. 110-343, 122 Stat. 3861, 3881-93 (2008), and the ACA.[7] The MHPAEA provides that, if a health plan includes both mental health and medical benefits, the coverage must be the same in terms of financial requirements, treatment limitations, and out-of-network coverage. MHPAEA § 512. Before the ACA, the MHAPEA did not apply to individual or small-group plans. *Id.* (applying only to group plans); 29 U.S.C. § 1185a(c)(1)(A) (2012) (exempting small employers from MHPAEA in Employee Retirement Income Security Act); 42 U.S.C. § 300gg-26(c) (2012) (excluding small employers from MHPAEA in Public Health Service Act). The ACA expanded the MHPAEA's parity requirements to apply to individual and small-group plans. *Standards Related to Essential Health Benefits*, 78 Fed. Reg. at 12,844, 12,867 (finalizing 45 C.F.R. § 156.115(a)(3) to require compliance with 45 C.F.R. § 146.136, which requires parity between mental-health and medical benefits).

Minnesota's benchmark plan states: "We cover services for: mental health diagnoses as described in the Diagnostic and Statistical Manual of Mental Disorders–Fourth Edition (DSM IV) (most recent edition) that lead to significant disruption of function in the member's life." Ex. 1 at 15. The plan covers outpatient and inpatient treatment and also generally covers mental-health treatment ordered by a Minnesota court. *Id.* at 15-16; *see also* Minn. Stat. §§ 62Q.47 (imposing parity requirements for mental health and medical coverage if plan covers mental health services), .53 (defining "medically necessary" as health care services that are appropriate for diagnosis or condition in terms of type, frequency, level, setting, and duration and providing that any plan that covers mental health services cannot impose a more restrictive

definition than the statutory definition), 535, subd. 2 (requiring plan that covers mental-health services to cover court-ordered mental-health services) (2012).

Thus, because fully-insured individual and small-group health plans offered in Minnesota on or after January 1, 2014 must provide EHB coverage that is substantially equal to that in the benchmark plan and because the benchmark plan provides mental health coverage, fully-insured individual and small-group plans offered in Minnesota must provide coverage for mental-health treatment effective January 1, 2014. Financial requirements, treatment limitations, and out-of-network coverage plans for mental health must be the same as for medical coverage. MHPAEA § 512; *Standards Related to Essential Health Benefits*, 78 Fed. Reg. at 12,867 (to be codified at 45 C.F.R. § 156.115(a)(3)).

D. Coverage For Autism Spectrum Disorder Treatment Under Minnesota's Benchmark Plan.

For qualified health plans offered through a state's insurance exchange, a state may require benefits in addition to those required as part of the EHB package. ACA § 1311(d)(3)(B)(i). In addition, the Commerce Department historically had authority to disapprove any policy form that contained unjust, unfair, or inequitable provisions. Minn. Stat. § 62A.02, subd. 3(a)(2) (2012). As noted above, the Commerce Department approved the policy that became Minnesota's default benchmark plan. The benchmark plan excludes coverage for "[i]ntensive behavioral therapy treatment programs for the treatment of autism spectrum disorders, including ABA, IEIBT and Lovaas." Ex. 1 at 24. This exclusion appears to be common in the industry in Minnesota. The Commerce Department has approved similar exclusions, for example, in policies issued by Blue Cross Blue Shield of Minnesota[8] (Ex. 3 at 20, 45) and Medica[9] (Ex. 4 at 74).

As set forth above, the Minnesota Legislature enacted a law this year providing that, "[b]y December 31, 2014, the Department of Commerce shall request that the United States Department of Human Services include autism services in Minnesota's Essential Health Benefits when the next benefit set is selected in 2016." In other words, the Legislature appears to have recognized that Minnesota's default benchmark plan expressly excludes such coverage.

As set forth below, in 2013, the Minnesota Legislature required fully-insured large employer health plans insuring employers with 50 or more employees to cover treatment of autism spectrum disorders effective January 1, 2014. Ex. 5. The Legislature also required such coverage for the State Employee Group Insurance Plan (SEGIP)[10] and state medical-assistance program.[11] The Legislature did not enact a similar law to require autism coverage by individual and small employer health plans. To the contrary, the State deferred to HHS to select a default benchmark plan for Minnesota that expressly excludes coverage for certain types of intensive behavioral therapy treatment programs for autism spectrum disorders.

It should be noted that there has been substantial litigation around the country seeking coverage under various health plans for intensive autism treatment for children. One case is pending in federal court in Minnesota. A mother sued various health plans and the Minnesota Department of Commerce alleging that they violated numerous federal and state laws, including the Americans with Disabilities Act and the Minnesota Human Rights Act, by approving or issuing discriminatory policies that exclude coverage for intensive behavioral therapy treatment for autism spectrum disorders. *See Reid ex rel. M.R. v. BCBSM, Inc.*, No. 12-cv-3005 (D. Minn. filed Nov. 30, 2012). A court has the authority to require coverage even if the Department of Commerce has approved its exclusion. *Shank v. Fid. Mut. Life Ins. Co.*, 21 N.W.2d 235, 238 (Minn. 1945).

II. LARGE EMPLOYER HEALTH PLANS.

A. Coverage For Mental Health Treatment by Large Employer Health Plans.

Large employers with at least 50 full-time employees are not required to cover EHBs. They are, however, subject to "assessable payments" if they do not provide full-time employees and their dependents with affordable "minimal essential coverage." ACA §§ 1513(a), 10106(f), *as amended by* HCERA § 1003. "Minimal essential coverage" is defined as merely coverage that arises from a governmental health plan, an employer–sponsored plan, a grandfathered health plan, a plan offered in a state's individual market, or any other health-benefits coverage. ACA § 1501(b); *see also id.* § 1513 (applying definition of minimum essential coverage from 26 U.S.C. § 5000A(f)(2), which was enacted in ACA § 1501). Under the MHPAEA, however, if a large employer covers mental-health services, the coverage must be the same as for medical coverage in terms of financial requirements, treatment limitations, and out-of-network coverage. MHPAEA § 512.

B. Coverage For Autism Spectrum Disorder Treatment By Fully-Insured Large Employer Health Plans.

In 2013, the Minnesota Legislature required that a fully-insured health plan issued to a large employer—defined as an employer with more than 50 current employees—"provide coverage for the diagnosis, evaluation, multidisciplinary assessment, and medically necessary care of children under 18 with autism spectrum disorders." Ex. 5, 2013 Minn. Laws. ch. 108, art. 12, § 3, at 1292-93 (enacting Section 62A.3094, subdivision 2, and incorporating definition of "large employer" from Section 62Q.18); *see also* Minn. Stat. § 62Q.18, subd. 1(3) (2012) (defining "large employer"). It has been estimated that about 14 percent of the State's population is covered under fully-insured large employer plans.[12] This is because large employers more commonly self-insure their health benefits under the Employee Retirement

Income Security Act, which generally preempts state coverage regulations. *See* 29 U.S.C. § 1144(a) (2012).

If you have any questions, please let me know.

Sincerely,

LORI SWANSON
Attorney General

cc: The Honorable Joe Atkins
The Honorable Thomas Huntley
The Honorable Tina Liebling
The Honorable Tony Lourey
The Honorable James Metzen
The Honorable Kathy Sheran
Mr. Brian Beutner, Chair, MNsure Board of Directors
Mr. Peter Benner, Vice-Chair, MNsure Board of Directors
Mr. Thompson Aderinkomi, MNsure Board of Directors
Dr. Kathryn Duevel, MNsure Board of Directors
Mr. Tom Forsythe, MNsure Board of Directors
Mr. Phil Norrgard, MNsure Board of Directors

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[1] 2013 Minn Laws ch. 108, art. 12, § 106, at 1349.

[2] 2013 Minn Laws ch. 108, art. 12, § 105, at 1349.

[3] 2013 Minn. Laws ch. 108, art. 12, § 107, at 1350.

[4] *See* Minn. Stat. § 62Q.01, subd. 3 (2012) (defining "health plan" to include definition provided in Section 62A.011); 2013 Minn. Laws ch. 84, art. 1, § 7, at 474-75 (amending Section 62A.011, subdivision 3).

[5] Sabrina Corlette et al., The Commonwealth Fund, *Implementing the Affordable Care Act: Choosing an Essential Health Benefits Benchmark Plan* 2, 5 (2013).

[6] In July 2012, HHS identified each state's largest small-group products. States then had two opportunities to select a benchmark plan: by September 30, 2012, and then by December 26, 2012. In February 2013, HHS issued its final rules implementing the ACA's EHB provisions and identified each state's benchmark plan. *See Standards Related to Essential Health Benefits*, 78 Fed. Reg. at 12,871 (identifying Minnesota's benchmark plan); Ctr. for Consumer Info. & Ins. Oversight, U.S. Dep't of Health & Human Servs., *Essential Health Benefits: List of the Largest Three Small Group Products by State* 10 (July 3, 2012) (identifying Minnesota's largest small-group products); Minn. Health Care Reform Task Force, *Roadmap to a Healthier Minn.: Recommendations of the Minn. Health Care Reform Task Force* 36 (Dec. 13, 2012) (noting task force's discussion of EHB, determination that few significant differences existed between Minnesota's benchmark-plan options, and recommendation that state revisit EHB for 2016 plan year); Minn. Health Care Reform Task Force, *Essential Health Benefits: Basic Facts & Frequently Asked Questions* 1, 5 (Oct. 5, 2012) (stating that Minnesota did not select benchmark plan by first deadline to select plan);

Minn. Dep't of Commerce, *Essential Health Benefits Activity to Date* (providing timeline of activity for State's Health Care Reform Task Force, including acknowledgements that Minnesota had not selected a benchmark plan), *available at* http://mn.gov/commerce/insurance/topics/medical/health-insurance-reform/essential-health-benefits/essential-health-benefits-activities.jsp (last visited August 19, 2013).

[7] 2013 Minn. Laws ch. 84, art. 1, §§ 68, 75, 89, at 516, 519, 533-34 (enacting Sections 62Q.021, subdivision 2, 62Q.47(d), and 62Q.81, providing that requirements to comply with ACA and MHPAEA became effective day after enactment, and providing that requirement to provide coverage for EHBs takes effect January 1, 2014).

[8] For example, on pages 20 and 45 of Blue Cross policy CMMHM132A, approved by the Commerce Department on April 27, 2012, the policy excludes coverage for: "[S]ervices for or related to intensive behavioral therapy programs for the treatment of autism spectrum disorders including, but not limited to: Intensive Early Intervention Behavioral Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas Therapy."

[9]For example, page 74 of the Medica Choice Passport Certificate of Coverage Form MIC MAN PPMN, approved by the Commerce Department on November 21, 2011, excludes coverage for: "Services for or related to intensive behavior therapy treatment programs for the treatment of autism spectrum disorders. Examples of such services include, but are not limited to, Intensive Early Intervention Behavior Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas therapy."

[10] The SEGIP autism coverage is effective the earlier of January 1, 2016 or the date the next collective bargaining agreement or compensation plan is approved. 2013 Minn. Laws ch. 108, art. 12, § 2, at 1292.

[11] 2013 Minn. Laws ch. 108, art. 7, § 14, at 1064-65.

[12] Maura Lerner, *Autism Insurance Mandate Wins Approval*, Star Trib., May 22, 2013, at 2B.

EXHIBIT 1

MINNESOTA EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	HealthPartners, Inc.
Product Name	Small Group Product
Plan Name	500 25 Open Access
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (FEDVIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	Yes

HealthPartners Open Access Choice
For Small Employers
Schedule of Payments

NOTICE: THIS DISCLOSURE IS REQUIRED BY MINNESOTA LAW. THIS CONTRACT IS EXPECTED TO RETURN ON AVERAGE 84.2 PERCENT OF YOUR PAYMENT DOLLAR FOR HEALTH CARE. THE LOWEST PERCENTAGE PERMITTED BY STATE LAW FOR THIS CONTRACT IS 82 PERCENT.

Effective Date: The later of the effective date, or most recent anniversary date, of the Master Group Contract and your effective date of coverage under the Master Group Contract.

See the Membership Contract for additional information about covered services and limitations.

The amount that we pay for covered services is listed below. The member is responsible for the specified dollar amount and/or percentage of charges that we do not pay.

HealthPartners Benefits are underwritten by HealthPartners, Inc.. APN and Non-Network Benefits are underwritten by HealthPartners Insurance Company. The HealthPartners Benefits constitute a comprehensive plan. The APN and Non-Network Benefits constitute non-qualified plans.

In HealthPartners Open Access Choice, you have direct access to any HealthPartners network providers listed in the HealthPartners Open Access Network provider directory.

Coverage may vary depending on whether you select a HealthPartners provider, APN Network provider or a Non-network provider.

These definitions apply to the Schedule of Payments. They also apply to the Contract.

Brand Drug: A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand drug has expired. A few brand drugs may be covered at the generic benefit level if it is indicated on the formulary.

Charge: For covered services delivered by participating network providers, is the provider's discounted charge for a given medical/surgical service, procedure or item.

For covered services delivered by non-network providers, is the provider's charge for a given medical/surgical service procedure or item, according to the usual and customary charge allowed amount.

The Usual and Customary Charge is the maximum amount allowed we consider in the calculation of payment of charges incurred for certain covered services. It is consistent with the charge of other providers of a given service or item in the same region.

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

HealthPartners®

Group Membership Contract

HealthPartners Open Access Choice
For Small Employers

CON-700.45 HPSE-C
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HEALTHPARTNERS MISSION

OUR MISSION IS TO IMPROVE THE HEALTH OF OUR MEMBERS, OUR PATIENTS AND THE COMMUNITY.

ABOUT HEALTHPARTNERS and 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 underwrites and administers the HealthPartners Benefits described in this Contract. HealthPartners is the parent company of a family of related organizations and provides administrative services for HealthPartners Insurance Company. When used in this Contract, "we", "us" or "our" has the same meaning as "HealthPartners" and its related organizations.

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

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

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

IMPORTANT ENROLLEE INFORMATION FOR HEALTHPARTNERS NETWORK SERVICES:

1. COVERED SERVICES. These are network services provided by participating HealthPartners network providers or authorized by those providers. This Contract fully defines what services are covered and describes procedures you must follow to obtain coverage.

2. PROVIDERS. Enrolling with HealthPartners does not guarantee services by a particular provider on the list of network providers. When a provider is no longer part of the HealthPartners network, you must choose among remaining HealthPartners network providers.

3. EMERGENCY SERVICES. Emergency services from providers outside the HealthPartners network will be covered only if proper procedures are followed. Read this Contract for the procedures, benefits and limitations associated with emergency care from HealthPartners network and non- HealthPartners network providers.

4. EXCLUSIONS. Certain services or medical supplies are not covered. Read this Contract for a detailed explanation of all exclusions.

5. CONTINUATION. You may continue coverage or convert to an individual HMO contract under certain circumstances. Read this Contract for a description of your continuation and conversion rights.

6. CANCELLATION. Your coverage may be cancelled by you or HealthPartners only under certain conditions. Read this Contract for the reasons for cancellation of coverage.

7. NEWBORN COVERAGE: If your health plan provides for dependent coverage, a newborn infant is covered from birth. HealthPartners will not automatically know of the newborn's birth or that you would like coverage under your plan. You should notify HealthPartners of the newborn's birth and that you would like coverage. If your contract requires an additional enrollment payment for each dependent, HealthPartners is entitled to all enrollment payments due from the time of the infant's birth until the time you notify us of the birth. HealthPartners may withhold payment of any health benefits for the newborn infant until any enrollment payments you owe are paid.

8. PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT: Enrolling with HealthPartners does not guarantee that any particular prescription drug will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the contract year.

ENROLLEE BILL OF RIGHTS FOR HEALTHPARTNERS NETWORK SERVICES

1. Enrollees have the right to available and accessible services including emergency services 24 hours a day and seven days a week.

2. Enrollees have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice.

3. Enrollees have the right to refuse treatment, and the right to privacy of medical or dental and financial records maintained by HealthPartners and its health care providers, in accordance with existing law.

4. Enrollees have the right to file a complaint with HealthPartners and the Commissioner of Health and the right to initiate a legal proceeding when experiencing a problem with HealthPartners or its health care providers.

5. Medicare enrollees have the right to voluntarily disenroll from HealthPartners and the right not to be requested or encouraged to disenroll, except in circumstances specified in federal law.

6. Medicare enrollees have the right to a clear description of nursing home and home care benefits covered by HealthPartners.

TERMS AND CONDITIONS OF USE OF THIS CONTRACT

1. This document may be available in printed and/or electronic form.

2. Only HealthPartners is authorized to amend this document.

3. Any other alteration to a printed or electronic plan document is unauthorized.

4. In the event of a conflict between printed or electronic plan documents only the authorized plan document will govern.

I. INTRODUCTION TO THE GROUP MEMBERSHIP CONTRACT

A. GROUP MEMBERSHIP CONTRACT

This Group Membership Contract (this Contract) is the enrollee's evidence of coverage, under the Master Group Contract issued by HealthPartners and HealthPartners Insurance Company to the enrollee's group health plan sponsor. The Master Group Contract provides for the medical coverage described in this Contract. It covers the enrollee and the enrolled dependents (if any) as named on the enrollee's membership application. The enrollee and his or her enrolled dependents are our members. This Contract replaces all contracts previously issued by us.

B. IDENTIFICATION CARD

An identification card will be issued to you at the time of enrollment. You will be asked to present your identification card, or otherwise show that you are a member, whenever you seek services. You may not permit anyone else to use your card to obtain care.

C. ASSIGNMENT OF BENEFITS

You may not assign or in any way transfer your rights under this Contract.

D. ENROLLMENT PAYMENTS

This Contract 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 contract 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.

E. BENEFITS

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

This Contract provides **Associated Provider Network Benefits (APN Benefits),** underwritten by HealthPartners Insurance Company for medical services delivered by participating APN network providers. This coverage is in addition to your comprehensive HMO coverage under this Contract. It is not used to fulfill the comprehensive HMO coverage required by law. This Contract describes your APN Benefits and how to obtain covered services.

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

You may be required to get prior authorization from CareCheck® before using certain benefits. There may be a reduction of benefits available to you, if you do not get prior authorization for those services. See "CareCheck®" in this Contract for specific information about prior authorization.

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

F. SCHEDULE OF PAYMENTS

Attached to this Contract is a Schedule of Payments, which is incorporated and fully made a part of this Contract. It describes the amounts of payments and limits for the coverage provided under this Contract. Refer to your Schedule of Payments for the amount of coverage applicable to a particular benefit. These benefits are further described in section III.

G. AMENDMENTS TO THIS CONTRACT

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

H. MASTER GROUP CONTRACT

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

I. CONFLICT WITH EXISTING LAW

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

J. HOW TO USE THE NETWORKS

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

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

Designated Physician, Provider or Facility: This is a current list of network physicians, providers or facilities which are authorized to provide certain covered services as described in this contract. Call Member Services for a current list.

Network Provider. This is any one of the participating licensed physicians, dentists, mental and chemical health or other health care providers, facilities and pharmacies listed in your network directory, which has entered into an agreement with HealthPartners to provide health care services to members.

For groups subject to ERISA, a provider listing will be sent to you automatically, and free of charge, as a separate document along with the Membership Contract.

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

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

1. ABOUT THE HEALTHPARTNERS NETWORK

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

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

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

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

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

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

Continuity of Care. In the event you must change your current primary care physician, specialty care physician or general hospital provider because that provider leaves the HMO 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 HMO benefit for up to 120 days under this contract if you qualify for continuity of care benefits.

Conditions that qualify for this benefit are:
1. an acute condition;
2. a life-threatening mental or physical illness;
3. pregnancy beyond the first trimester of pregnancy;
4. 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
5. 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.

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

Referrals and Authorizations for HealthPartners Services.

There is no referral requirement for services delivered by providers within your network. Your physician may be required to obtain prior authorization for certain services. Your physician will coordinate the 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 www.healthpartners.com for a list of which services require your physician to obtain prior authorization. You also must obtain authorization from us to see non-network providers for the care delivered by non-network providers to be covered as HealthPartners Benefits.

Our medical or dental directors, or their designees, make coverage determinations of medical necessity and 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.

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 addition 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 and CareCheck® Decisions in section V. "Disputes and Complaints" for a description of how to proceed.

Your physician will obtain an authorization for (1) residential care for the treatment of eating disorders as an alternative to inpatient care in a licensed facility when medically necessary; (2) psychiatric residential treatment for emotionally handicapped children; and (3) mental health services provided in the home.

Contracted convenience care clinics are designated on our website when you log on to your "*my*HealthPartners" account at www.healthpartners.com. You must use a designated convenience care clinic to obtain the convenience care benefit shown in your Schedule of Payments.

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

Durable medical equipment and supplies must be obtained from or repaired by approved vendors.

Non-emergent, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) must be provided at a designated facility. Your physician or facility will obtain or verify authorization for these services with HealthPartners, as needed.

All services for the purpose of weight loss must be provided by a designated physician. Your physician or facility will obtain or verify authorization for these services with HealthPartners, as needed.

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

Psychiatric residential treatment for emotionally handicapped children must be provided at designated facilities. Your physician or facility will obtain authorization for these services from HealthPartners, as needed.

For specialty drugs that are self-administered, you must obtain the specialty drugs from a designated vendor to be covered as HealthPartners Benefits. Coverage is described in the Schedule of Payments.

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

2. ABOUT THE APN NETWORK

To obtain APN Benefits for covered services, you must select and receive services from APN network providers.

Associated Provider Network (APN). This is the network of participating APN network providers described in the provider listing.

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

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 APN 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 APN network benefit for up to 120 days under this contract if you qualify for continuity of care benefits.

Conditions that qualify for this benefit are:

1. an acute condition;
2. a life-threatening mental or physical illness;
3. pregnancy beyond the first trimester of pregnancy;
4. 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
5. 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.

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

Authorizations and Referrals for APN Services

There is no referral requirement for services delivered by providers within your network. Your physician may be required to obtain prior authorization for certain services. Your physician will coordinate the 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 www.healthpartners.com for a list of which services require your physician to obtain 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 APN Benefits.

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 and CareCheck® Decisions section V. "Disputes and Complaints" for a description of how to proceed.

Your physician will obtain an authorization for (1) residential care for the treatment of eating disorders as an alternative to inpatient care in a licensed facility when medically necessary; (2) psychiatric residential treatment for emotionally handicapped children; and (3) mental health services provided in the home.

Contracted convenience care clinics are designated on our website when you log on to your "*my*HealthPartners" account at www.healthpartners.com. You must use a designated convenience care clinic to obtain the convenience care benefit shown in your Schedule of Payments.

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

Durable medical equipment and supplies must be obtained from or repaired by approved vendors.

Non-emergent, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) must be provided at a designated facility. Your physician or facility will obtain or verify authorization for these services with HealthPartners, as needed.

All services for the purpose of weight loss must be provided by a designated physician. Your physician or facility will obtain or verify authorization for these services with HealthPartners, as needed.

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

Psychiatric residential treatment for emotionally handicapped children must be provided at designated facilities. Your physician or facility will obtain authorization for these services from HealthPartners, as needed.

For specialty drugs that are self-administered, you must obtain the specialty drugs from a designated vendor to be covered as APN Benefits. Coverage is described in the Schedule of Payments.

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

K. CARECHECK® (Applicable to Non-Network Benefits only)

It is your responsibility to notify CareCheck® of all services requiring review, as shown in 1. below. Failure to follow CareCheck® procedures may result in a reduction of the amount otherwise payable to you under this Contract. You can designate another person to contact CareCheck® for you.

1. **CARECHECK® Services.** CareCheck® is HealthPartners' utilization review program. CareCheck® must precertify all inpatient confinement and same day surgery, new, experimental or reconstructive outpatient technologies or procedures, durable medical equipment or prosthetics costing over $3,000, home health services after your visits exceed 30, and skilled nursing facility stays. When you call CareCheck®, a utilization management specialist reviews your proposed treatment plan. CareCheck® provides certification and determines appropriate length of stay, additional days and reviews the quality and appropriateness of care.

2. **Procedure To Follow To Receive Maximum Benefits**

   a. **For medical emergencies.** A certification request is to be made by phone to CareCheck® as soon as reasonably possible after the emergency. You will not be denied full coverage because of your failure to gain certification prior to your emergency.

b. **For medical non-emergencies.** A phone call must be made to CareCheck® when services requiring precertification are scheduled, but not less than 2 working days prior to that date. CareCheck® advises the physician and the hospital, or skilled nursing facility, by phone, if the request is approved. This will be confirmed by written notice within ten days of the decision.

3. **Failure to Comply With CareCheck® Requirements.** With respect to Non-Network Benefits, if you fail to make a request for precertification of services in the time noted above, but your services requiring precertification are subsequently approved as medically necessary, we will reduce the eligible charges by 20%.

4. **CareCheck® Certification Does Not Guarantee Benefits.** CareCheck® does not guarantee either payment or the amount of payment. Eligibility and payment are subject to all of the terms of the Contract.

5. **Information Needed When You Call CareCheck®**

When you or another person contacts CareCheck®, this information is needed:

- the enrollee's name, address, phone number and member number;
- the patient's name, birth date, the relationship to the enrollee and the patient's member number;
- the attending physician's name, address, and phone number;
- the facility's name, address, and phone number;
- the reason for the inpatient admission and/or proposed surgical procedure.

6. **Pre-certification Process.**

When certification 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.

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

If the initial determination is made not to approve, we will notify your health care provider and hospital, if appropriate, by telephone within one working day of the determination, and we will send written verification with details of the denial.

If you want to request an expedited review, or have received a denial of a pre-certification and want to request an appeal, you have a right to do so. If your complaint is not resolved to your satisfaction under certain circumstances, you may request an external review. Refer to the information regarding Appeals Involving Medical Necessity Determinations and CareCheck® Decisions in section V. "Disputes and Complaints" for a description of how to proceed.

How to contact CareCheck®: You may call **(952)-883-6400** in the Minneapolis/St. Paul metro area or **1-800-316-9807** outside the metro area from 8:00 a.m. to 5:00 p.m. (Central Time) weekdays. You can leave a recorded message at other times. You may also write CareCheck® at Quality Utilization Management Department, 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

L. ACCESS TO RECORDS AND CONFIDENTIALITY

We comply with the state and federal laws governing the confidentiality and use of protected health information and medical records. When your provider releases health information to us according to state law, we can use your protected health information, when necessary, for certain health care operations, including, but not limited to: claims processing, including claims we make for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, case management, care coordination and utilization management, disease management, underwriting; premium rating, claims experience reporting to your employer or other health plan sponsor; (only upon certification by your employer or plan sponsor of the compliance of plan documents with

the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")), the evaluation of potential or actual claims against us, auditing and legal services, and other access and use without further authorization if permitted or required by another law. 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.

M. YOUR RIGHT TO A CERTIFICATE OF COVERAGE UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

HIPAA requires all health plans or group health plan sponsors to send HIPAA Certificates of Coverage (commonly referred to as "HIPAA certs" or "certs") to all individuals currently or previously covered on a medical plan. If your group health plan sponsor elects to send their own HIPAA certs or have a Third Party Administrator (TPA) send them instead of having us send them, the following requirements would apply to your group health plan sponsor or their designated TPA.

We are required to send HIPAA certs upon request or when your coverage terminates under our plan. HIPAA certs are documents that provide evidence of your prior/current medical coverage. HIPAA certs provided by us must reflect the length of continuous medical coverage that you had under your group health plan sponsor's plan with HealthPartners. When your medical coverage is cancelled, we will automatically send you a HIPAA cert. We will also send you a HIPAA cert if you request one. You may request a Certificate of Coverage by calling the Member Services phone number or address printed on your identification card. If you have active medical coverage and request a HIPAA cert, then we must produce a HIPAA cert indicating that the coverage is 'continuing.' The HIPAA Law also states that health plans must be able to reproduce original certificates of coverage for a minimum of 24 months after the date that your coverage under our plan terminates.

II. DEFINITIONS OF TERMS USED

Actively at work. This is the time period in which an enrollee is customarily performing all the regular duties of his/her occupation, at the usual place of employment or business, or at some location to which that employment requires travel. An enrollee is considered actively at work for the time period absent from work solely by reason of vacation or holiday, if the enrollee was actively at work on the last preceding regular work day.

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

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

CareCheck® Service. This is a pre-certification and utilization management program. It reviews, authorizes and coordinates the appropriateness and quality of care for certain services for members, as covered in the Non-Network Benefits of this Contract.

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

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

Continuous Coverage. This is the maintenance of continuous and uninterrupted qualifying coverage by an eligible employee or dependent. An eligible employee or dependent is considered to have maintained continuous coverage if the individual requests enrollment in this plan within 63 days of termination of the qualifying coverage.

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

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

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

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

Dentally Necessary. This is care which is limited to diagnostic testing, treatment, and the use of dental equipment and appliances which, in the judgment of a dentist, is required to prevent deterioration of dental health, or to restore dental function. The member's general health condition must permit the necessary procedure(s).

Eligible Dependents. These are the persons shown below. Under this Contract, a person who is considered an enrollee is not qualified as an eligible dependent. A person who is no longer an eligible dependent (as defined below) on an enrollee's Contract may qualify for continuation of coverage within the group and/or conversion to non-group coverage, as provided in section VIII. of this Contract.

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

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

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

3. **Qualified Grandchild.** This is an enrollee's unmarried grandchild who is a newborn, and who resides with and is financially dependent on the covered grandparent. The child must be either under 26 years of age or a disabled dependent, as described below.

4. **Disabled Dependent.** This is an enrollee's dependent as referred to in 2. and 3. above, who is beyond the limiting age and physically handicapped or mentally disabled, and dependent on the enrollee for the majority of his/her financial support. The disability must have come into existence prior to attainment of age 26. Disability does not include pregnancy. "Disabled" means incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder, or physical handicap. The enrollee must give us a written request for coverage of a disabled dependent. The request must include written proof of disability and must be approved by us, in writing. We must receive the request within 31 days of the date an already enrolled dependent becomes eligible for coverage under this definition, or when adding a new disabled dependent eligible 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 Master Group Contract, applies for membership and is accepted by us for coverage under this Contract.

Enrollment Date. This is the first day of coverage under the Contract, 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 service in accordance with applicable governmental licensing privileges and limitations.

Group Health Plan Sponsor. This is the purchaser of this Contract'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 normal motor development. To be considered habilitative, measurable functional improvement and measurable progress must be made toward achieving functional goals, within a predictable period of time toward a member's maximum potential ability.

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

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.

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

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

1. Whether 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); if the drug or device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials; or if the drug, device or medical treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and

2. Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether a drug is included in any authoritative compedia as identified by the Medicare program for use in the determination of a medically necessary accepted indication of drugs and biologicals used off-label, as appropriate for its proposed use; and

3. Whether there are consensus opinions of national and local health care providers in the applicable specialty as determined by a sampling of providers, including whether there are protocols used by the treating facility or another facility studying the same drug, device, medical treatment or procedure.

Late Entrant. This is an eligible enrollee of the group health plan sponsor, or the eligible enrollee's dependent, requesting enrollment for coverage under the Master Group Contract, after the applicable eligibility period has expired in accordance with the group health plan sponsor's Master Group Contract, provided that the initial enrollment period is a period of at least 30 days. However, an eligible enrollee or dependent is not considered a late entrant if:

1. the individual was covered under qualifying existing coverage at the time the individual was eligible to enroll in this plan, declined enrollment on that basis, and presents to us a certificate of termination of the qualifying prior coverage, due to loss of eligibility for that coverage, or proof of the termination of the group health plan sponsor's payment toward that coverage, provided that the individual maintains continuous coverage and requests enrollment within 30 days of termination of qualifying coverage or termination of the group health plan sponsor's payment toward that coverage. For purposes of this clause, an individual is not a late entrant if the individual elects coverage under the health benefit plan rather than accepting continuation coverage for which the individual is eligible under state or federal law with respect to the individual's previous qualifying coverage;

2. the individual has lost coverage under another group health plan due to the expiration of benefits available under the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law Number 99-272, as amended, and any state continuation laws applicable to the employer or carrier, provided that the individual maintains continuous coverage and requests enrollment within 30 days of the loss of coverage;
3. the individual is the new spouse of an eligible enrollee, and the enrollee requests coverage of such spouse within the applicable eligibility period in accordance with the group health plan sponsor's Master Group Contract, provided that the initial enrollment period for the new spouse is a period of at least 30 days;
4. the individual is a new dependent child of an eligible enrollee, and the enrollee requests coverage of such dependent child within the applicable eligibility period in accordance with the group health plan sponsor's Master Group Contract, provided that the initial enrollment period for the dependent child is a period of at least 30 days;
5. the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or
6. a court has ordered that coverage be provided for a former spouse or a dependent child under an enrollee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order.
7. the individual enrolls for coverage during a special enrollment period.

Medically Necessary Care. This is diagnostic testing and medical treatment which is medically appropriate to the member's physical or mental diagnosis for an injury or illness, and preventive services covered in this Contract. Medically necessary care must meet the following criteria:

1. it meets clinically accepted medical services and practice parameters of the general medical community; and
2. it is an appropriate type of service delivered at an appropriate frequency and level of care, and in an appropriate setting for the member's condition; and
3. it restores or maintains health; or
4. it prevents deterioration of the member's condition; or
5. it prevents the reasonably likely onset of a health problem or detects an incipient problem.

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

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

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

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

Period of Confinement. This is (a) one continuous hospitalization, or (b) a series of hospitalizations or skilled nursing facility stays or periods of time when the member is receiving home health services for the same medical condition in which the end of one is separated from the beginning of the next by less than 90 days. For the purpose of this definition, "same condition" means illness or injury related to former illness or injury in that it is either within the same ascertainable diagnosis or set of diagnoses, or within the scope of complications or related conditions.

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

Pre-existing Condition. This is, with respect to coverage, any condition present before the member's enrollment date for the coverage for which medical advice, diagnosis, care or treatment was recommended or received, during the six months immediately preceding the enrollment date under this Contract. Genetic information or pregnancy will not be considered a pre-existing condition. The pre-existing condition limitation does not apply to members under age 19.

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.

Qualifying Coverage. This is health benefits or health coverage provided under:

1. a health benefit plan, as defined in this section, but without regard to whether it is issued to a small employer and including blanket accident and sickness insurance, other than accident-only coverage, as defined in section 62A.11; or
2. part A or part B of Medicare; or
3. medical assistance under Minnesota Statutes, chapter 256B; or
4. general assistance medical care under Minnesota Statutes, chapter 256D; or
5. MCHA; or
6. a self-insured health plan; or
7. MinnesotaCare plan established under Minnesota Statutes, section 256.L02; or
8. Minnesota Employees Insurance Program (MEIP) and Public Employees Insurance Program (PEIP), provided under Minnesota Statutes, section 43.A316, 43A.317, or 471.617; or
9. a Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or other coverage provided under United States Code, title 10, chapter 55; or
10. a health care network cooperative under chapter 62R or a health provider cooperative under chapter 62R.17; or
11. a medical care program of the Indian Health Service or of a tribal organization; or
12. the federal Employees Health Benefits Plan, or other coverage provided under United States Code, title 5, chapter 89;
13. a health benefit plan under section 5(e) of the Peace Corps Act, codified as United States Code, title 22, section 2504(e); or
14. a health plan; or
15. a plan similar to any of the above plans provided in this state or in another state as determined by the Commissioner; or
16. any plan established or maintained by the state, the United States government, or a foreign country, or any political subdivision of a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan; or
17. the State Children's Health Insurance Program (SCHIP).

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

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

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

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

III. DESCRIPTION OF COVERED SERVICES

HealthPartners agrees to cover the services described below and on the Schedule of Payments. The Schedule of Payments describes the level of payment that applies for each of the covered services. To be covered under this section, the medical or dental services or items described below must be medically or dentally necessary.

Coverage for eligible services is subject to the exclusions, limitations, and other conditions of this Contract.

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. These medical policies (medical coverage criteria) are available by calling Member Services, or log on to your "*my*HealthPartners" account at www.healthpartners.com.

A. AMBULANCE AND MEDICAL TRANSPORTATION. We cover ambulance and medical transportation for medical emergencies and as shown below.

For HealthPartners and APN Benefits. Transfers between network hospitals for treatment by network physicians are covered, if initiated by a network physician. Transfers from a hospital or to home or to other facilities are covered, if medical supervision is required en route.

B. BEHAVIORAL HEALTH

1. **Mental Health Services.**

We cover services for: mental health diagnoses as described in the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM IV) (most recent edition) that lead to significant disruption of function in the member's life.

We also provide coverage for mental health treatment ordered by a Minnesota court under a valid court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. We must be given a copy of the court order and the behavioral care evaluation, and the service must be a covered benefit under this plan, and the service must be provided by a network provider, or other provider as required by law. We cover the evaluation upon which the court order was based if it was provided by a network provider. We also provide coverage for the initial mental health evaluation of a child, regardless of whether that evaluation leads to a court order for treatment, if the evaluation is ordered by a Minnesota juvenile court.

a. **Outpatient Services (including intensive outpatient and day treatment):** We cover outpatient professional mental health services for evaluation, crisis intervention, and treatment of mental health disorders.

A comprehensive diagnostic assessment will be made of each patient as the basis for a determination by a mental health professional, concerning the appropriate treatment and the extent of services required.

Outpatient services we cover for a diagnosed mental health condition include the following:

1) Individual, group, family, and multi-family therapy;
2) Medication management provided by a physician, certified nurse practitioner, or physician's assistant;
3) Psychological testing services for the purposes of determining the differential diagnoses and treatment planning for patients currently receiving behavioral health services;
4) Day treatment and intensive outpatient services in a licensed program;
5) Partial hospitalization services in a licensed hospital or community mental health center; and
6) Psychotherapy and nursing services provided in the home if authorized by us.

b. **Inpatient Services:** We cover inpatient services in a hospital and professional services for treatment of mental health disorders. Medical stabilization is covered under inpatient hospital services in the "Hospital and Skilled Nursing Facility Services" section.

We cover residential care for the treatment of eating disorders in a licensed facility, as an alternative to inpatient care, when it is medically necessary and your physician obtains authorization from us.

We also cover medically necessary psychiatric residential treatment for emotionally handicapped children as diagnosed by a physician. This care must be authorized by us and provided by a hospital or residential treatment center licensed by the local state or Health and Human Services Department. The child must be under 18 years of age and an eligible dependent according to the terms of this Contract. Services not covered under this benefit include shelter services, correctional services, detention services, transitional services, group residential services, foster care services and wilderness programs.

2. Chemical Health Services.

We cover medically necessary services for assessments by a licensed alcohol and drug counselor and treatment of Substance-Related Disorders as defined in the latest edition of the DSM IV.

a. **Outpatient Services (including intensive outpatient and day treatment):** We cover outpatient professional services for the diagnosis and treatment of chemical dependency. Chemical dependency treatment services must be provided by a program licensed by the local Health and Human Services Department.

Outpatient services we cover for a diagnosed chemical dependency condition include the following:

(1) Individual, group, family, and multi-family therapy provided in an office setting;
(2) We cover opiate replacement therapy including methadone and buprenorphine treatment; and
(3) Day treatment and intensive outpatient services in a licensed program.

b. **Inpatient Services:** We cover inpatient services in a hospital or a licensed residential primary treatment center.

We cover services provided in a hospital that is licensed by the local state and accredited by Medicare.

Detoxification Services. We cover detoxification services in a hospital or community detoxification facility if it is licensed by the local Health and Human Services Department.

Covered services are based on established medical policies, which are subject to periodic review and modification by the medical directors. These medical policies (medical coverage criteria) are available by calling Member Services, or log on to your "*my*HealthPartners" account at www.healthpartners.com.

C. **CHIROPRACTIC SERVICES.** We cover chiropractic services for rehabilitative care, provided to diagnose and treat acute neuromusculo-skeletal conditions.

Massage therapy which is performed in conjunction with other treatment/modalities by a chiropractor, is part of a prescribed treatment plan and is not billed separately is covered.

D. DENTAL SERVICES

1. Accidental Dental Services

a. **Accidental Dental Services Within the Networks:** We cover services dentally necessary to treat and restore damage done to sound, natural, unrestored teeth as a result of an accidental injury. Coverage is for damage caused by external trauma to face and mouth only, not for cracked or broken teeth which result from biting or chewing. When an implant-supported dental prosthetic treatment is pursued, the accidental dental benefit will be applied to the prosthetic procedure. Benefits are limited to the amount that would be paid toward the placement of a removable dental prosthetic appliance that could be used in the absence of implant treatment. Care must be provided or pre-authorized by a HealthPartners dentist.

b. **Emergency Accidental Dental Services Outside the Networks:** We cover emergency accidental dental services provided by a non-network dentist to the same extent as eligible services specified above.

2. Medical Referral Dental Services.

a. **Medically Necessary Outpatient Dental Services:** We cover medically necessary outpatient dental services. Coverage is limited to dental services required for treatment of an underlying medical condition, e.g., removal of teeth to complete radiation treatment for cancer of the jaw, cysts and lesions.

b. **Medically Necessary Hospitalization and Anesthesia for Dental Care:** We cover medically necessary hospitalization for dental care. This is limited to charges incurred by a member who: (1) is a child under age 5; (2) is severely disabled; (3) has a medical condition, and requires hospitalization or general anesthesia for dental care treatment; or (4) is a child between age 5 and 12 and care in dental offices has been attempted unsuccessfully and usual methods of behavior modification have not been successful, or when extensive amounts of restorative care, exceeding 4 appointments, are required. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist professional fees are not covered.

c. **Medical Complications of Dental Care:** We cover medical complications of dental care. Treatment must be medically necessary care and related to medical complications of non-covered dental care, including complications of the head, neck, or substructures.

3. **Oral Surgery:** We cover oral surgery. Coverage is limited to treatment of medical conditions requiring oral surgery, such as treatment of oral neoplasm, non-dental cysts, fracture of the jaws, and trauma of the mouth and jaws.

4. **Treatment of Cleft Lip and Cleft Palate:** We cover treatment of cleft lip and cleft palate of a dependent child, to the limiting age in the definition of an "Eligible Dependent", including orthodontic treatment and oral surgery directly related to the cleft. Benefits for individuals age 26 up to the limiting age for coverage of the dependent are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. Dental services which are not required for the treatment of cleft lip or cleft palate are not covered. If a dependent child covered under this Contract is also covered under a dental plan which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same copayment, conditions and limitations as durable medical equipment.

5. **Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD):** We cover surgical and non-surgical treatment of temporomandibular disorder (TMD) and craniomandibular disorder (CMD), which is medically necessary care. Dental services which are not required to directly treat TMD or CMD are not covered.

E. **DIAGNOSTIC IMAGING SERVICES.** We cover diagnostic imaging, when ordered by a provider and provided in a clinic or outpatient hospital facility.

For HealthPartners and APN Benefits, non-emergent, scheduled outpatient Magnetic Resonance Imaging (MRI) and computing Tomography (CT) must be provided at a designated facility. Your physician and facility will obtain or verify authorization for these services with HealthPartners, as needed.

F. **DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES.** We cover equipment and services, as described below.

1. Subject to the limitations below, we cover durable medical equipment and services, including certain disposable supplies, enteral feedings and the following diabetic supplies and equipment: glucose monitors, insulin pumps, syringes, blood and urine test strips and other diabetic supplies as deemed medically appropriate and necessary, for members with gestational, Type I or Type II diabetes.

   Diabetic supplies and equipment are limited to certain models and brands.

   We cover special dietary treatment for Phenylketonuria (PKU) and oral amino acid based elemental formula if it meets our medical coverage criteria.

   External hearing (including osseointegrated or bone anchored) aids for members age 18 or younger who have hearing loss that is not correctable by other covered procedures. Coverage is limited to one hearing aid for each ear every three years.

2. Coverage of durable medical equipment is limited by the following:
   a. Payment will not exceed the cost of an alternate piece of equipment or service that is effective and medically necessary.
   b. For prosthetic benefits, other than hair prostheses (i.e., wigs) for hair loss resulting from alopecia areata and oral appliances for cleft lip and cleft palate, payment will not exceed the cost of an alternate piece of equipment or service that is effective and medically necessary and enables members to conduct standard activities of daily living.
   c. We reserve the right to determine if an item will be approved for rental vs. purchase.

3. Items which are not eligible for coverage include, but are not limited to:
   a. Replacement or repair of any covered items, if the items are (i) damaged or destroyed by member misuse, abuse or carelessness, (ii) lost; or (iii) stolen.
   b. Duplicate or similar items.
   c. Labor and related charges for repair of any covered items which are more than the cost of replacement by an approved vendor.
   d. Sales tax, mailing, delivery charges, service call charges.
   e. Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience or recreation.
   f. Communication aids or devices: equipment to create, replace or augment communication abilities including, but not limited to, hearing aids (implantable and external, including osseointegrated or bone anchored) and fitting of hearing aids, except as required by law, speech processors, receivers, communication boards, or computer or electronic assisted communication, except as described in this Contract. This exclusion does not apply to cochlear implants, which are covered as described in the medical coverage criteria. Medical coverage criteria are available by calling Member Services, or log on to your "*my*HealthPartners" account at www.healthpartners.com.
   g. Household equipment which primarily has customary uses other than medical, such as, but not limited to, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds.
   h. Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas.
   i. Modifications to the structure of the home including, but not limited to, its wiring, plumbing or charges for installation of equipment.
   j. Vehicle, car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier.
   k. Rental equipment while member's owned equipment is being repaired by non-contracted vendors, beyond one month rental of medically necessary equipment.

l. Other equipment and supplies, including but not limited to assistive devices, that we determine are not eligible for coverage.

Durable medical equipment and supplies must be obtained from or repaired by approved vendors.

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. Our coverage policy for diabetic supplies includes information on our required models and brands. These medical policies (medical coverage criteria) are available by calling Member Services, or log on to your "*my*HealthPartners" account at www.healthpartners.com.

G. EMERGENCY AND URGENTLY NEEDED CARE SERVICES

Emergency Care. These are services to treat: (1) the sudden, unexpected onset of illness or injury which, if left untreated or unattended until the next available clinic or office hours, would result in hospitalization, or (2) a condition requiring professional health services immediately necessary to preserve life or stabilize health.

When reviewing claims for coverage of emergency services, our medical director will take into consideration a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next working day or next available clinic appointment.

Urgently Needed Care. These are services to treat an unforeseen illness or injury, which are required in order to prevent a serious deterioration in your health, and which cannot be delayed until the next available clinic or office hours.

We cover services for emergency care and urgently needed care if the services are otherwise eligible for coverage under this Contract.

H. HEALTH EDUCATION. We cover education for preventive services and education for the management of chronic health problems (such as diabetes).

I. HOME HEALTH SERVICES. We cover skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy, and other therapeutic services, prenatal and postnatal services, child health supervision services, phototherapy services for newborns, home health aide services, and other eligible home health services when provided in the member's home, if the member is homebound (i.e., unable to leave home without considerable effort due to a medical condition. Lack of transportation does not constitute homebound status). For phototherapy services for newborns and high risk pre-natal services, supplies and equipment are included.

We cover total parenteral nutrition/intravenous ("TPN/IV") therapy, equipment, supplies and drugs in connection with IV therapy. IV line care kits are covered under Durable Medical Equipment.

We cover palliative care benefits. Palliative care includes symptom management, education and establishing goals of care. We waive the requirement that you be homebound for a limited number of home visits for palliative care (as shown in the schedule of payments), if you have a life-threatening, non-curable condition which has a prognosis of two years or less. Additional palliative care visits are eligible under the home health services benefit if you are homebound and meet all other requirements defined in this section.

You do not need to be homebound to receive total parenteral nutrition/intravenous ("TPN/IV") therapy.

Home health services are eligible and covered only when they are:

1. medically necessary; and
2. provided as rehabilitative care, terminal care or maternity care; and
3. ordered by a physician, and included in the written home care plan.

Home health services are not provided as a substitute for a primary caregiver in the home or as relief (respite) for a primary caregiver in the home. We will not reimburse family members or residents in the member's home for the above services.

A service shall not be considered a skilled nursing service merely because it is performed by, or under the direct supervision of, a licensed nurse. Where a service (such as tracheotomy suctioning or ventilator monitoring) or like

services, can be safely and effectively performed by a non-medical person (or self-administered), without the direct supervision of a licensed nurse, the service shall not be regarded as a skilled nursing service, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it a skilled service when a skilled nurse provides it. Only the skilled nursing component of so-called "blended" services (i.e., services which include skilled and non-skilled components) are covered under this Contract.

J. HOME HOSPICE SERVICES

Applicable Definitions:

Part-time. This is up to two hours of service per day, more than two hours is considered continuous care.

Continuous Care. This is from two to twelve hours of service per day provided by a registered nurse, licensed practical nurse, or home health aide, during a period of crisis in order to maintain a terminally ill patient at home.

Appropriate Facility. This is a nursing home, hospice residence, or other inpatient facility.

Custodial Care Related to Hospice Services. This means providing assistance in the activities of daily living and the care needed by a terminally ill patient which can be provided by primary caregiver (i.e., family member or friend) who is responsible for the patient's home care.

1. **Home Hospice Program.** We cover the services described below for members who are terminally ill patients and accepted as home hospice program participants. Members must meet the eligibility requirements of the program, and elect to receive services through the home hospice program. The services will be provided in the patient's home, with inpatient care available when medically necessary as described below. Members who elect to receive hospice services do so in lieu of curative treatment for their terminal illness for the period they are enrolled in the home hospice program.

    a. Eligibility: In order to be eligible to be enrolled in the home hospice program, a member must: (1) be a terminally ill patient (prognosis of six months or less); (2) have chosen a palliative treatment focus (i.e., emphasizing comfort and supportive services rather than treatment attempting to cure the disease or condition); and (3) continue to meet the terminally ill prognosis as reviewed by our medical director or his or her designee over the course of care. A member may withdraw from the home hospice program at any time.

    b. Eligible Services: Hospice services include the following services provided by Medicare-certified providers, if provided in accordance with an approved hospice treatment plan.
        (1) Home Health Services:
            (a) Part-time care provided in the member's home by an interdisciplinary hospice team (which may include a physician, nurse, social worker, and spiritual counselor) and medically necessary home health services are covered.
            (b) One or more periods of continuous care in the member's home or in a setting which provides day care for pain or symptom management, when medically necessary, will be covered.
        (2) Inpatient Services: We cover medically necessary inpatient services.
        (3) Other Services:
            (a) Respite care is covered for care in the member's home or in an appropriate facility, to give the patient's primary caregivers (i.e., family members or friends) rest and/or relief when necessary in order to maintain a terminally ill patient at home.
            (b) Medically necessary medications for pain and symptom management.
            (c) Semi-electric hospital beds and other durable medical equipment are covered.
            (d) Emergency and non-emergency care is covered.

2. **What Is Not Covered.** We do not cover the following services:
    a. financial or legal counseling services; or
    b. housekeeping or meal services in the patient's home; or
    c. custodial care related to hospice services, whether provided in the home or in a nursing home; or
    d. any service not specifically described as covered services under this home hospice services benefits; or
    e. any services provided by members of the patient's family or residents in the member's home.

K. HOSPITAL AND SKILLED NURSING FACILITY SERVICES

1. Medical or Surgical Hospital Services.

a. **Inpatient Hospital Services:** We cover the following medical or surgical services, for the treatment of acute illness or injury, which require the level of care only provided in an acute care facility. These services must be authorized by a physician.

Inpatient hospital services include: room and board; the use of operating or maternity delivery rooms; intensive care facilities; newborn nursery facilities; general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, prescription drugs or other medications administered during treatment, blood and blood products (unless replaced), and blood derivatives, and other diagnostic or treatment related hospital services; physician and other professional medical and surgical services provided while in the hospital.

We cover up to 120 hours of services provided by a private duty nurse or personal care assistant who has provided home care services to a ventilator-dependent patient, solely for the purpose of assuring adequate training of the hospital staff to communicate with that patient.

Services for items for personal convenience, such as television rental, are not covered.

We cover, following a vaginal delivery, a minimum of 48 hours of inpatient care for the mother and newborn child. We cover, following a caesarean section delivery, a minimum of 96 hours of inpatient care for the mother and newborn child. If the duration of inpatient care is less than these minimums, we also cover a minimum of one home visit by a registered nurse for post-delivery care, within 4 days of discharge of the mother and newborn child. Services provided by the registered nurse include, but are not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. We shall not provide any compensation or other non-medical remuneration to encourage a mother and newborn to leave inpatient care before the duration minimums specified. Services for items for personal convenience, such as television rental, are not covered.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

b. **Outpatient Hospital, Ambulatory Care or Surgical Facility Services:** We cover the following medical and surgical services, for diagnosis or treatment of illness or injury on an outpatient basis. These services must be authorized by a physician.

Outpatient services include: use of operating rooms, maternity delivery rooms or other outpatient departments, rooms or facilities; and the following outpatient services: general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, drugs administered during treatment, blood and blood products (unless replaced) and blood derivatives, and other diagnostic or treatment related outpatient services; physician and other professional medical and surgical services provided while an outpatient.

For HealthPartners and APN Benefits, non-emergent, scheduled outpatient Magnetic Resonance Imaging (MRI) and computing Tomography (CT) must be provided at a designated facility. Your physician and facility will obtain or verify authorization for these services with HealthPartners, as needed.

To see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see the benefits under Diagnostic Imaging Services, Laboratory Services and Physical Therapy in the Schedule of Payments.

2. **Skilled Nursing Facility Care.** We cover room and board, daily skilled nursing and related ancillary services for post acute treatment and rehabilitative care of illness or injury, following a hospital confinement.

L. INFERTILITY SERVICES.

We cover the diagnosis of infertility. These services include diagnostic procedures and tests provided in connection with an infertility evaluation, office visits and consultations to diagnose infertility.

M. LABORATORY SERVICES. We cover laboratory tests when ordered by a provider and provided in a clinic or outpatient hospital facility.

N. LYME DISEASE SERVICES. We cover services for the treatment of Lyme disease.

O. MASTECTOMY RECONSTRUCTION BENEFIT.

We cover reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.

P. OFFICE VISITS FOR ILLNESS OR INJURY. We cover the following when medically necessary: professional medical and surgical services and related supplies, including biofeedback, of physicians and other health care providers; blood and blood products (unless replaced) and blood derivatives.

We cover diagnosis and treatment of illness or injury to the eyes. Where contact or eye glass lenses are prescribed as medically necessary for the post-operative treatment of cataracts or for the treatment of aphakia, or keratoconous, we cover the initial evaluation, lenses and fitting. Members must pay for lens replacement beyond the initial pair.

We also provide coverage for the initial physical evaluation of a child if it is ordered by a Minnesota juvenile court.

Q. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY.

We cover the following physical therapy, occupational therapy and speech therapy services:
(1) rehabilitative care to correct the effects of illness or injury;
(2) habilitative care rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development.

Massage therapy which is performed in conjunction with other treatment/modalities by a physical or occupational therapist, is part of a prescribed treatment plan and is not billed separately is covered.

R. PORT WINE STAIN REMOVAL SERVICES. We cover port wine stain removal services.

S. PRESCRIPTION DRUG SERVICES. We cover prescription drugs and medications, which can be self-administered or are administered in a physician's office. We cover off-label use of formulary drugs to treat cancer if the drug is recognized for the treatment of cancer in any authoritative compendia used by the Medicare program.

T. PREVENTIVE SERVICES. We cover the following eligible preventive services.
1. Routine health exams and periodic health assessments. A physician or health care provider will counsel members as to how often health assessments are needed based on the age, sex and health status of the member.
2. Child health supervision services, including pediatric preventive services, routine immunizations, developmental assessments and laboratory services appropriate to the age of the child from birth to 72 months, and appropriate immunizations to age 18.
3. Routine prenatal care and exams to include visit-specific screening tests, education and counseling.
4. Routine postnatal care and exams to include health exams, assessments, education and counseling relating to the period immediately after childbirth.
5. Routine screening procedures for cancer.

6. Routine eye and hearing exams.
7. Professional voluntary family planning services.
8. Adult immunizations.

Routine preventive services will be as defined by federal and state law. Covered services are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. These medical policies (medical coverage criteria) are available by calling Member Services, or log on to your "*my*HealthPartners" account at www.healthpartners.com.

U. **SPECIFIED NON-NETWORK SERVICES.** We cover the following services when you elect to receive them from a non-network provider, at the same level of coverage we provide when you elect to receive the services from a network provider:

1. Voluntary family planning of the conception and bearing of children.
2. The provider visit(s) and test(s) necessary to make a diagnosis of infertility.
3. Testing and treatment of sexually transmitted diseases (other than HIV).
4. Testing for AIDS or other HIV-related conditions.

V. TRANSPLANT SERVICES

Autologous. This is when the source of cells are from the individual's own marrow or stem cells.

Allogeneic. This is when the source of cells are from a related or unrelated donor's marrow or stem cells.

Autologous Bone Marrow Transplant. This is when the bone marrow is harvested from the individual and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is reinfused (transplanted).

Allogeneic Bone Marrow Transplant. This is when the bone marrow is harvested from the related or unrelated donor and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is reinfused (transplanted).

Autologous/Allogeneic Stem Cell Support. This is a treatment process that includes stem cell harvest from either bone marrow or peripheral blood, tumor ablation with high-dose chemotherapy and/or radiation, stem cell reinfusion, and related care. Autologous/allogeneic bone marrow transplantation and high dose chemotherapy with peripheral stem cell rescue/support are considered to be autologous/allogeneic stem cell support.

Designated Transplant Center. This is any health care provider, group or association of health care providers designated by us to provide services, supplies or drugs for specified transplants for our members.

Transplant Services. This is transplantation (including retransplants) of the human organs or tissue listed below, including all related post-surgical treatment and drugs and multiple transplants for a related cause. Transplant services do not include other organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, except surgical implantation of FDA approved Ventricular Assist Devices (VAD), functioning as a temporary bridge to heart transplantation.

What is covered. We cover eligible transplant services (as defined above) while you are our member. Transplants that will be considered for coverage are limited to the following:

1. Kidney transplants for end-stage disease.
2. Cornea transplants for end-stage disease.
3. Heart transplants for end-stage disease.
4. Lung transplants or heart/lung transplants for: (1) primary pulmonary hypertension; (2) Eisenmenger's syndrome; (3) end-stage pulmonary fibrosis; (4) alpha 1 antitrypsin disease; (5) cystic fibrosis; and (6) emphysema.
5. Liver transplants for: (1) biliary atresia in children; (2) primary biliary cirrhosis; (3) post-acute viral infection (including hepatitis A, hepatitis B antigen e negative and hepatitis C) causing acute atrophy or post-necrotic cirrhosis; (4) primary sclerosing cholangitis; and (5) alcoholic cirrhosis; and (6) hepatocellular carcinoma.

6. Allogeneic bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for: (1) acute myelogenous leukemia; (2) acute lymphocytic leukemia; (3) chronic myelogenous leukemia; (4) severe combined immunodeficiency disease; (5) Wiskott-Aldrich syndrome; (6) aplastic anemia; (7) sickle cell anemia; (8) non-relapsed or relapsed non-Hodgkin's lymphoma; (9) multiple myeloma; and (10) testicular cancer.
7. Autologous bone marrow transplants or peripheral stem cell support associated with high-dose chemotherapy for: (1) acute leukemias; (2) non-Hodgkin's lymphoma; (3) Hodgkin's disease; (4) Burkitt's lymphoma; (5) neuroblastoma; (6) multiple myeloma; (7) chronic myelogenous leukemia; and (8) non-relapsed non-Hodgkin's lymphoma.
8. Pancreas transplants for simultaneous pancreas-kidney transplants for diabetes, pancreas after kidney, living related segmental simultaneous pancreas kidney transplantation and pancreas transplant alone.

For HealthPartners and APN Benefits, charges for transplant services must be incurred at a designated transplant center.

The transplant-related treatment provided, including the expenses incurred for directly related donor services, shall be subject to and in accordance with the provisions, limitations, maximums and other terms of this Contract.

Medical and hospital expenses of the donor are covered only when the recipient is a member and the transplant and directly related donor expenses have been prior authorized for coverage. Treatment of medical complications that may occur to the donor are not covered. Donors are not considered members, and are therefore not eligible for the rights afforded to members under this contract.

IV. SERVICES NOT COVERED

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

1. Treatment, procedures, or services or drugs which are not medically necessary and/or which are primarily educational in nature or for the vocation, comfort, convenience, appearance or recreation of the member, including cognitive retraining and skills training.
2. For HealthPartners coverage, treatment, procedures or services which are not provided by a network physician or other authorized network provider. There are certain exceptions, as described in "Emergency and Urgently Needed Care Services" and "Specified Non-Network Services".
3. For APN coverage, treatment, procedures or services which are not provided by a network physician or other authorized network provider.
4. Procedures, technologies, treatments, facilities, equipment, drugs and devices which are considered investigative, or otherwise not clinically accepted medical services. We consider vagus nerve stimulator treatment for the treatment of depression and Quantitative Electroencephalogram treatment for the treatment of behavioral health conditions to be investigative and do not cover these services. We consider the following transplants to be investigative and do not cover them: surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, non-human organ implants and/or transplants and other transplants not specifically listed in this Contract.
   While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered.
5. Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders, including ABA, IEIBT and Lovaas.
6. Rest and respite services, except as respite services are specifically described in section III. under the subsection "Home Hospice Services" and custodial care. This includes all services, medical equipment and drugs provided for such care.
7. Halfway houses, residential treatment services, extended care facilities, or comparable facilities, foster care, adult foster care and family child care provided or arranged by the local state or county.
8. Services associated with non-covered services, including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies.
9. Services from non-medically licensed facilities or providers and services outside the scope of practice or license of the individual or facility providing the service.
10. Cosmetic surgery, cosmetic services and treatments primarily for the improvement of the member's appearance or self-esteem. This exclusion does not apply to services for port wine stain removal and reconstructive surgery.

11. Dental treatment, procedures or services not listed in this Contract.
12. Vocational rehabilitation and recreational or educational therapy. Recreation therapy is therapy provided solely for the purpose of recreation, including but not limited to: (a) requests for physical therapy or occupational therapy to improve athletic ability, and (b) braces or guards to prevent sports injuries.
13. Health services and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise medically necessary, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI), competency evaluations, and adoption studies.
14. Court ordered treatment, except as described under section III. C. 1. "Mental Health Services" and section III. Q.P. "Office Visits for Illness and Injury" or as otherwise required by law.
15. Reversal of sterilization, assisted reproduction, including, but not limited to gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), intracytoplasmic sperm injection (ICSI), and/or in-vitro fertilization (IVF), and all charges associated with such procedures; treatment of infertility, including but not limited to, office visits, laboratory and diagnostic imaging services; surrogate pregnancy and related obstetric/maternity benefits; and sperm, ova or embryo acquisition, retrieval or storage; however, we do cover office visits and consultations to diagnose infertility.
16. Services and/or surgery for gender reassignment, except as determined medically necessary.
17. Routine foot care, except as they meet criteria for medically necessary care.
18. Keratotomy and keratorefractive surgeries, eyeglasses, contact lenses and their fitting, measurement and adjustment, and hearing aids (implantable and external, including osseointegrated or bone anchored) and their fitting, except as specifically described in this Contract. This exclusion does not apply to cochlear implants, which are covered as described in the medical coverage criteria. Medical coverage criteria are available by calling Member Services, or log on to your "*my*HealthPartners" account at www.healthpartners.com.
19. Enteral feedings, unless they are the sole source of nutrition used to treat a life-threatening condition, nutritional supplements, over-the-counter electrolyte supplements and infant formula, except as required by Minnesota law. This exclusion does not apply to oral amino acid based elemental formula if it meets our medical coverage criteria.
20. Charges for sales tax.
21. Genetic counseling and genetics studies, except when the results would influence a treatment or management of a condition or family planning decision. Our medical policies (medical coverage criteria) are available by calling Member Services, or log on to your "*my*HealthPartners" account at www.healthpartners.com.
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. This exclusion does not apply if the covered person is also covered under Medical Assistance under Minnesota chapter 256B to the extent that the services are covered under section 256B.0625, subdivision 7, with the exception of section 256B.0654, subdivision 4.
25. A pre-existing condition is not covered until:
    (a) the end of 12 months from the enrollment date for a member who is not considered a late entrant; or
    (b) the end of 18 months from the enrollment date for a member who is considered a late entrant.

    The pre-existing condition limitation is reduced by any period of time during which the member had continuous and qualifying coverage prior to his or her enrollment under this Contract, including any waiting period applicable under this Contract. The pre-existing condition limitation does not apply to members under age 19.
26. Services that are provided to a member, who also has other primary insurance coverage for those services and who does not provide us the necessary information to pursue Coordination of Benefits, as required under this Contract.
27. The portion of a billed charge for an otherwise covered service by a non-network provider, which is in excess of the usual and customary charges. We also do not cover charges or a portion of a charge which is either a duplicate charge for a service or charges for a duplicate service.
28. Charges for services (a) for which a charge would not have been made in the absence of insurance or health plan coverage, or (b) which the member is not obligated to pay, and (c) from providers who waive copayment, deductible and coinsurance payments by the member, except in cases of undue financial hardship.
29. Provider and/or member travel and lodging incidental to travel, regardless if it is recommended by a physician.
30. Health club memberships.
31. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
32. Autopsies.
33. Massage therapy for the purpose of comfort or convenience of the member.
34. For HealthPartners Network and APN Network coverage, charges incurred for transplants, Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) received at facilities which are not designated facilities, or charges incurred for weight loss services provided by a physician who is not a designated physician.

35. Accident related dental services if treatment is (1) provided to teeth which are not sound and natural, (2) to teeth which have been restored, (3) initiated beyond six months from the date of the injury; (4) received beyond the initial treatment or restoration or (5) received beyond twenty-four months from the date of injury.
36. Nonprescription (over the counter) drugs or medications, unless listed on the formulary and prescribed by a physician or legally authorized health care provider under applicable state law, including, but not limited to, vitamins, supplements, homeopathic remedies, and non-FDA approved drugs. We cover off-label use of drugs to treat cancer as specified in the "Prescription Drug Services" section of this Contract.
37. Charges for elective home births.
38. Professional services associated with substance abuse intervention. A "substance abuse intervention" is a gathering of family and/or friends to encourage a person covered under this contract to seek substance abuse treatment.
39. Services provided by naturopathic providers.
40. Oral surgery to remove wisdom teeth.
41. Acupuncture.
42. All drugs used for the treatment of sexual dysfunction.
43. All drugs used for the treatment of infertility.
44. Orthognathic treatment or procedures and all related services.
45. All drugs used for acid reflux and stomach ulcers for which there are over-the-counter therapeutic alternatives.
46. All oral antihistamines for which there are over-the-counter therapeutic alternatives.
47. Bariatric surgery.
48. Treatment, procedures, or services or drugs which are provided when you are not covered under this Contract.

V. DISPUTES AND COMPLAINTS

A. DETERMINATION OF COVERAGE

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

B. COMPLAINTS

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

2. **Definitions:**

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

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

3. **Complaint and Appeal Process**

a. **Complaints:**

A complainant may submit a complaint to the Member Services Department either in writing or orally. A written complaint will be considered a first level appeal under the appeal process described in paragraph b. Member Services will make every effort to resolve the complaint. The Member Services

Department will investigate the complaint and provide for informal discussions. If the oral complaint is not resolved to the complainant's satisfaction within 10 calendar days of receipt of the complaint, we will provide an appeal form to the complainant, which must be completed and returned to the Member Services Department for further consideration. We will offer to assist the complainant in completing this form. We will also offer to complete the form and mail it to the complainant for a signature.

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

At any time, the complainant may also file a complaint with the Commissioner of Health regarding HealthPartners benefits, either in writing or by calling (651) 201-5100, or toll-free 1-800-657-3916 or the Commissioner of Commerce regarding APN Benefits or Non-Network benefits at (651) 296-2488, or toll-free at 1-800-657-3602.

b. **Appeal Process:**

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

1. **First Level Appeal.** You or your authorized representative may 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/HealthPartners Insurance Company
   Member Services Department
   8170 33rd Avenue South
   P.O. Box 1309
   Minneapolis, MN 55440-1309
   Telephone: (952) 883-5000 Outside the metro area: 1-800-883-2177
   TDD Telephone Number: (952) 883-5127 Outside the metro area: 1-888-850-4762

   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 complaint.

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

   Appeals Involving Medical Necessity Determinations or Precertifications by CareCheck®.

   If the appeal concerns urgent services, you 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 30 calendar days.

   These time periods may be extended for up to 14 days if you agree.

   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.

   All notifications described above will comply with applicable law.

2. **Second Level Appeal.** If your request was denied after the first level appeal of a medical necessity determination or precertification by CareCheck®, you have the right to request external review of our decision. See below for a description of this process. If your request was denied after the first level appeal of any other issue, you or your authorized representative may submit a written request for a second level appeal, including any relevant documents, and submit issues, comments and additional information as appropriate to:

HealthPartners/HealthPartners Insurance Company
Member Services Department
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: (952) 883-5000 Outside the metro area: 1-800-883-2177
TDD Telephone Number: (952) 883-5127 Outside the metro area: 1-888-850-4762

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 phone. Hearings and written reconsiderations shall include the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, providers, or other persons, as is deemed necessary for a fair appraisal and resolution of the appeal. During your appeal, upon your request we will provide you, free of charge, reasonable access to all documents, records and other information relevant to your appeal.

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

These time periods may be extended if you agree.

4. External Complaint Procedures:

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

VI. CONDITIONS

A. RIGHTS OF REIMBURSEMENT AND SUBROGATION

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

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

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

B. COORDINATION OF BENEFITS

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

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

1. **Applicability.**
   a. This coordination of benefits (COB) provision applies to this Contract when an enrollee or the enrollee's covered dependent has health care coverage under more than one plan. "Plan" and "This Plan" are defined below.
   b. If this coordination of benefits provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:
      (1) shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but
      (2) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in paragraph 4. below.

2. **Definitions.**
   a. **"Plan"** is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
      (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
      (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

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

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

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

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

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

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

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

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

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

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

3. **Order Of Benefit Determination Rules.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. **Effect On The Benefits Of This Plan.**
   a. **When This Section Applies.** This paragraph 4. applies when, in accordance with paragraph 3. "Order of Benefit Determination Rules", This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B. immediately below.
   b. **Reduction in This Plan's Benefits.** The benefits of This Plan will be reduced when the sum of:
      (1) the benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
      (2) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

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

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

7. **Right Of Recovery.** If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of:
   a. the persons it has paid or for whom it has paid;
   b. insurance companies; or
   c. other organizations.

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

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

C. MEDICARE AND THIS CONTRACT

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

Medicare is the primary payer for members with end stage renal disease, after the 30 month period following the earlier of (1) the month in which the member begins a regular course of renal dialysis, or (2) the first of the month in which the member became entitled to Medicare, if the member 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 members under age 65, who are covered by Medicare because of disability (other than end stage renal disease), when: (1) the group health plan sponsor of This Plan employs fewer than 100 employees and the member or their spouse or parent has group health plan coverage due to current employment, or (2) the member 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 Contract are not intended to duplicate any benefits to which members are, or would be, entitled under Medicare. All sums payable under Medicare for services provided pursuant to this Contract shall be payable to and retained by us. Each member shall complete and submit to us such consents, releases, assignments and other documents as may be requested by us in order to obtain or assure reimbursement under Medicare for which members are eligible.

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

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

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

VII. EFFECTIVE DATE AND ELIGIBILITY

A. 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 Master Group Contract.

An employee must be actively at work on the initial effective date of coverage or coverage for the employee and dependents will be delayed until the date the employee returns to work. The effective date of coverage shall not be delayed if the employee is not actively at work on the effective date of coverage due to the employee's health status, medical condition, or disability.

B. 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 Contract 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 Contract to be effective on the eligibility date. Coverage under this Contract is subject to the pre-existing condition limitation in section IV.

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 at any time, subject to the pre-existing condition limitation in section IV.

Special Enrollment Period. If you are eligible, but not enrolled for coverage under this Contract, or your dependent, if the dependent is eligible but not enrolled for coverage under this Contract, you or your dependent may enroll for coverage under the terms of this Contract 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, one of the events listed in c. (2) above.

Dependents may enroll if: (a) a group health plan makes coverage available with respect to your dependent; (b) you are covered under the Contract (or have met any waiting period applicable to becoming covered under the Contract and are eligible to be enrolled under the Contract 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 Contract shall provide for a dependent special enrollment period during which the person may be enrolled under this Contract 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 a member 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; or

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

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.

Enrollment of Newborn or Newly Adopted Children. Newborn infants (including a newborn grandchild of a covered grandparent) and a newly adopted child, may be covered without being subject to the pre-existing condition limitation, regardless of when notice is received by us. However, you must make required payments, if any, from the date of eligibility for a newborn infant (including a newborn grandchild of a covered grandparent) and a newly adopted child. If you do not make the required payments, we may reduce the eligible benefits for the applicable dependent by the amount due.

C. 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 made by us or the group health plan sponsor requires 31-day advance written notice.

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

VIII. CONTINUATION OF GROUP COVERAGE OR CONVERSION TO NON-GROUP COVERAGE

If your eligibility for group coverage under this Contract ends because of one of the events shown below, called "qualifying events," you may be eligible to continue group coverage, or to convert to non-group (individual) coverage. Each of these options is shown below.

A. CONTINUATION OF GROUP COVERAGE

1. **Qualifying Events.** Coverage under this Contract may be continued by an enrollee, spouse and other dependents, enrolled at the time coverage would otherwise end, or 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 Medicare.
   f. For a retired enrollee, spouse and other dependents, the bankruptcy filing by a former employer, under Title XI, United States Code, on or after July 1, 1986.
2. **Duration of Continuation Coverage.** The maximum period coverage can be continued depends on the qualifying event. It may be terminated earlier as shown below. The maximum period of continuation coverage starts on the day of the qualifying event.
   a. **Maximum period.**
      (1) Termination and reduced hours. The maximum period of continuation coverage is 18 months. If a second qualifying event, other than the employer's bankruptcy, occurs during the 18 months, the maximum period of continuation coverage is 36 months. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".
      (2) Disabled enrollee, spouse or dependent child. If the enrollee, spouse or other dependent is disabled under Title II or XVI of the Social Security Act, at any time during the first 60 days of continuation coverage, the 18-month maximum continuation period may be extended to 29 months. The disabled person must notify the group health plan sponsor within 60 days of the date of determination of disability, and within the initial 18-month continuation period. If a second qualifying event (other than bankruptcy) occurs during the extended 29-month period, the maximum period of continuation coverage is 36 months. See part B. "Disabled Enrollee" below, which describes your rights for coverage as a disabled enrollee under Minnesota law.

(3) Bankruptcy. In the case of bankruptcy of a retired enrollee's former employer, the maximum period of continuation coverage is until the death of the retired enrollee. In the case of the surviving spouse or dependent children of the retired enrollee, the maximum period of continuation coverage is 36 months after the death of the retired enrollee.

(4) Divorce or legal separation. Under Minnesota law, there is no maximum period of coverage for a former spouse or dependents who lose coverage due to divorce or legal separation. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".

(5) Death of enrollee. Under Minnesota law, there is no maximum period of coverage for a surviving spouse and dependents who lose coverage due to the death of the enrollee. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".

(6) Other qualifying events. The maximum period of continuation coverage for all other qualifying events is 36 months.

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

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

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

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

(4) Termination of extended coverage for disability. In case a person receives extended (29-month) continuation coverage due to disability at the time of termination or reduced hours, the extended coverage terminates at the beginning of the month 30 days after a final determination that the person is no longer disabled. See part B. "Disabled Enrollee" below, which describes your rights for coverage as a disabled enrollee under Minnesota law.

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

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 received, 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.

4. **Procedures for Providing Notices Required Under This "Continuation of Group Coverage or Conversion to Non-Group Coverage".**

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

B. CONVERSION TO NON-GROUP MEMBERSHIP

1. **Eligibility for Conversion Coverage.** After an enrollee, enrolled dependents or survivors have exhausted their benefits under Part A. Continuation of Group Coverage", they are eligible to apply for non-group conversion coverage of the type then in effect and available when application is made. This right to convert enables enrollees and enrolled dependents or survivors to enroll for health coverage without supplying evidence of good health. This right may be exercised by making application:
   a. Within 63 days of the date the enrollee or dependent has exhausted his or her continuation right as described in part A. above.
   b. Within 63 days of the date of termination of an enrollee's or dependent's group coverage, if the enrollee or dependent is not eligible for continuation under Part A. above.

   If elected, your conversion coverage takes effect on the date group coverage ceases or continuation eligibility terminates. You must submit the required non-group enrollment prepayment along with your application to convert.
2. **Exception to your right for Conversion Coverage.** An enrollee or his or her enrolled dependents will not be allowed to convert to HealthPartners non-group membership if any of the following has occurred:
   a. the enrollee's group coverage was ended for cause under section IX. "Termination", paragraphs 1., 2. and 7; or
   b. the enrollee's group health plan sponsor replaces us with another group health program prior to conversion or the group health plan sponsor terminates HealthPartners coverage and continues to offer other group health coverage; or
   c. the enrollee or an enrolled dependent moves out of the service area, unless we can reasonably arrange for the availability of insurance coverage in the new area, to be purchased at the enrollee's expense.

C. DISABLED ENROLLEE

Pursuant to the provisions of Minnesota Statute 62A.148, the group health plan sponsor and we agree not to terminate, suspend or otherwise restrict the participation in, or the receipt of, benefits otherwise payable hereunder, to any enrollee who becomes totally disabled while employed by the group health plan sponsor and covered hereunder while this Contract is in force, solely due to absence caused by such total disability. The group health plan sponsor may require the enrollee to pay all or some part of the payment for coverage in this instance. Such payment shall be made to the group health plan sponsor by that enrollee.

For the purpose of this section the term "total disability" means (a) the inability of an injured or ill enrollee to engage in or perform the duties of the enrollee's regular occupation or employment within the first two years of such disability and (b) after the first two years of such disability, the inability of the enrollee to engage in any paid employment or work for which the enrollee may, by education or training, including rehabilitative training, be or reasonably become qualified.

D. REPLACEMENT OF COVERAGE AND CONFINED MEMBERS

When the group health plan sponsor replaces the Master Contract with that of another health plan offering similar benefits, coverage will be extended for a member who is confined in an institution or institutions for medical care or treatment that would otherwise be covered under this Contract. Coverage will be extended only for services related to the condition for which the confinement is required. Coverage for these services will end on the earlier of the date of discharge or the date benefits provided under the Contract are exhausted.

E. PUBLIC EMPLOYEES

Certain retired employees of public or governmental entities and their dependents may be eligible for continued coverage upon retirement, pursuant to Minnesota Statute 471.61. If you qualify under this law, you may be required to pay the entire premium for continued coverage and will be required to notify your employer within certain deadlines, of your intent to continue coverage.

IX. TERMINATION

A member's coverage under this Contract terminates, when any of the following events occur.

1. The enrollment 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 Contract will continue in effect during the grace period. If no payment is received by us within the 31-day grace period, we will send the enrollee a notice of termination, stating that coverage will terminate 30 days from the date of notice for the enrollee and dependent. Coverage terminates, retroactive to the paid through date, but not more than 60 days prior to the end of the notice period. We are not obligated to accept any payment after the end of the grace period.

2. You are expected to pay all copayments and deductibles. If you do not make full payment, coverage under this Contract may terminate on the date following 30 days' advance notice by us.

3. When an enrollee ceases to be eligible under the terms of the Master Group Contract, 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 section VIII. A. above.

4. When an enrolled dependent no longer meets this Contract'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 section VIII. A. above.

5. When the maximum period under the group continuation coverage described in section VIII. A. above expires for an enrollee or dependent.

6. When the Master Group Contract is terminated, either as requested by us or the health plan sponsor, in accordance with the terms of the Master Group Contract.

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 Contract or deny a claim for benefits covered under this Contract for loss incurred or disability commencing after the expiration of the two year period beginning from the issue date of this Contract.

If an enrollee or enrollee's dependent no longer meets the group health plan sponsor's eligibility requirements, or if the group health plan sponsor has forwarded enrollment for an enrollee or enrollee's dependent to us, regardless of whether such enrollee or enrollee's dependent meets their eligibility requirements, we are required to obtain the enrollee or enrollee's dependent's signature before we may retroactively terminate coverage under this Contract. If a required signature is not obtained, the group health plan sponsor is required to pay the premium for an enrollee or enrollee's dependent up to the date of termination. A signature is not required for retroactive termination for any other reason, including, but not limited to, voluntary or involuntary termination of employment or because the enrollee or enrollee's dependent committed fraud or misrepresentation with respect to eligibility or any other material fact.

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

X. CLAIMS PROVISIONS

1. **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' claims 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.**

2. **Claim Forms.** After receiving notice of claim, we will furnish you a claim form for filing your proof of loss. If you don't receive this 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.

3. **Proof of Loss.** You must submit an itemized bill which documents the date and type of service, provider name and charges for covered services. Bills must be submitted within 90 days after the date services were first received. Where this section provides for payments contingent upon a period of confinement, these 90 days shall begin at the

end of the period for which we are liable. If you do not furnish proof within 90 days as required, benefits shall still be paid for that loss if (1) it was not reasonably possible to give proof within those 90 days and (2) proof is furnished as soon as reasonably possible. Any bills for covered services must be submitted to the plan within 15 months of incurring the charges. Any bill received 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.

4. **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 will notify you of our benefit determination if you have any remaining liability within 30 days of receipt of a completed claim. This time period may be extended by us for an additional 15 days for circumstances beyond our control.

5. **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.

6. **Physical Examinations and Autopsy.** This provision applies to APN Benefits and Non-Network Benefits. 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.

7. **Information.** When you seek coverage for goods or services under this Plan, you grant us the right to collect and review any claims, eligibility, coordination of benefits, rights of subrogation or medical 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, we reserve the right to refuse to grant coverage for claims for which we have incomplete documentation.

XI. 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 Membership Contract. 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.

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 Section VIII of this Group Membership Contract.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health plan insurer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance With Your Questions

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

XII. 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 Membership Contract's benefits: HealthPartners For all other matters: your employer.
Named Fiduciary:	For this Group Membership Contract's benefits: HealthPartners For all other matters: your employer.
Funding:	This Group Membership Contract is fully insured under Minnesota law.
Network Providers:	HealthPartners and APN Networks
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.

EXHIBIT 2

State: Minnesota ***Filing Company:*** HealthPartners, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO
Product Name: 700.45 HPSE-C HMO Flex Plans
Project Name/Number: 700.45 HPSE-C HMO Flex Plans/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved - Forms Only	Brian Pennington 651-296-8218	04/27/2011	04/27/2011

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Note to Company	Brian Pennington 651-296-8218	04/20/2011	04/20/2011
Note to Company	Brian Pennington 651-296-8218	04/14/2011	04/14/2011

Response Letters

Responded By	Created On	Date Submitted
Barbara Stier	04/25/2011	04/25/2011
Barbara Stier	04/14/2011	04/14/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Rate Filing Reference	Note To Reviewer	Barbara Stier	04/05/2011	04/12/2011
Related Rate Filing	Note To Filer	Melane Milbert	04/11/2011	04/11/2011
Actuarial OK	Reviewer Note	Melane Milbert	04/12/2011	

EXHIBIT 3

SERFF Tracking #:	*BCMN-128296626*	***State Tracking #:***	*C BP BCMN-128296626*	***Company Tracking #:***	*X18630*

State:	*Minnesota*	***Filing Company:***	*Blue Cross Blue Shield of Minnesota*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)*		
Product Name:	*2012 BCBSM Individual GoBlue for Healthy MN Contribution Program Contract X18630*		
Project Name/Number:	*2012 BCBSM Individual GoBlue for Healthy MN Contribution Program Contract X18630/X18630*		

Form Schedule

Lead Form Number: X18630

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved 04/27/2012	2012 BCBSM Individual GoBlue for Healthy MN Contribution Program Contract X18630	X18630	POL	Initial			2012 BCBSM Individual GoBlue for Healthy MN Contribution Program Contract X18630 FINAL 042412.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

INDIVIDUAL

GoBlue for Healthy MN Contribution Program

HEALTH PLAN

CONTRACT

NOTE: GoBlue for Healthy MN Contribution Program provides benefits for prenatal care only and does not cover maternity-related services such as health care professional and hospital/facility charges for labor, delivery, and postpartum care. This contract is single coverage only, no dependents may be added. This contract is not available to individuals younger than 19 or older than 64 years of age.

BlueCross BlueShield of Minnesota

An independent licensee of the Blue Cross and Blue Shield Association

[MEMBER NAME]
[ADDRESS]
[ADDRESS]
[ADDRESS]
[ADDRESS]

Group Number: XXXXXXXXXXXXXXX XXXXXXX
Identification Number: ON FILE
Type of Coverage: XXXXXXXXXXX

With Behavioral Health Care Coverage Option:

BEHAVIORAL HEALTH MENTAL HEALTH CARE

The Plan Covers:	In-Network Tier One Providers	In-Network Tier Two Providers	Out-of-Network Providers
• Outpatient health care professional charges for services including: ▪ assessment and diagnostic services ▪ individual/group/family therapy (office/in-home mental health services) ▪ neuro-psychological examinations • Outpatient hospital/outpatient behavioral health treatment facility charges for services including: ▪ evaluation and diagnostic services ▪ individual/group therapy ▪ crisis evaluation ▪ observation beds ▪ family therapy • Professional health care charges for services including: ▪ clinical based partial programs ▪ clinical based day treatment ▪ clinical based Intensive Outpatient Programs (IOP) • Facility health care charges for services including: ▪ hospital based partial programs ▪ hospital based day treatment ▪ hospital based Intensive Outpatient Programs (IOP) • Inpatient health care professional charges • Inpatient hospital/inpatient behavioral health treatment facility charges for services including: ▪ all eligible inpatient services ▪ emergency holds • Residential behavioral health treatment facility charges • Outpatient health care professional lab and diagnostic imaging • Outpatient hospital/facility lab and diagnostic imaging • Inpatient health care professional lab and diagnostic imaging • Inpatient hospital/facility lab and diagnostic imaging	You pay nothing after deductible.	You pay 20% coinsurance after deductible.	You pay 40% coinsurance after deductible, plus you pay any charges billed to you that exceed the Allowed Amount.

NOTES:

- **Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Please see the "Notification Requirements" section.**
- All eligible inpatient hospital/facility services combined are limited to 45 days per person per calendar year when you use an Out-of-Network Provider.

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NOTES:

- All eligible inpatient professional services combined are limited to 45 days per person per calendar year when you use an Out-of-Network Provider.
- Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a physician or a licensed psychologist, a licensed alcohol and drug dependency counselor or a certified chemical dependency assessor is deemed medically necessary.
- Court-ordered treatment for mental health care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity. Court-ordered treatment will be covered if it is determined to be medically necessary and otherwise covered under this contract.
- Outpatient family therapy is covered if part of a recommended treatment plan.
- Treatment of emotionally disabled children in a residential behavioral health treatment facility is covered the same as any other inpatient hospital medical admission.
- Psychoeducation is covered for individuals diagnosed with schizophrenia, bipolar disorder, and borderline personality disorder. Psychoeducational programs are delivered by an eligible provider to the patient on a group or individual basis as part of a comprehensive treatment program. Patients receive support, information, and management strategies specifically related to their diagnosis.

NOT COVERED:

- services for or related to intensive behavioral therapy programs for the treatment of autism spectrum disorders including, but not limited to: Intensive Early Intervention Behavioral Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas Therapy
- services for mental illness not listed in the most recent edition of the *International Classification of Diseases*
- custodial care, nonskilled care, adult daycare or personal care attendants
- services or confinements ordered by a court or law enforcement officer that are not medically necessary
- evaluations that are not performed for the purpose of diagnosing or treating mental health disorders including, but not limited to: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; parental competency and domestic violence programs
- room and board for foster care, group homes, incarceration, shelter, shelter care, and lodging programs
- halfway house services
- services for or related to marriage/couples training for the primary purpose of relationship enhancement including, but not limited to: premarital education; or marriage/couples retreats, encounters or seminars
- services for marriage/couples therapy/counseling not related to the treatment of a covered member's diagnosable mental health disorder
- education services with the exception of nutritional education for individuals diagnosed with anorexia nervosa, bulimia or eating disorders NOS (not otherwise specified)
- skills training
- therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment or support for the foster child's improved functioning)
- services for the treatments of learning disabilities
- therapeutic day care and therapeutic camp services
- hippotherapy (equine movement therapy)
- charges made by a health care professional for email and physician/patient telephone consultations, except for eligible E-Visits
- please refer to the "General Exclusions" section

With Behavioral Health Care Coverage Option:

BEHAVIORAL HEALTH SUBSTANCE ABUSE CARE

The Plan Covers:	In-Network Tier One Providers	In-Network Tier Two Providers	Out-of-Network Providers
• Outpatient health care professional charges for services including: ▪ assessment and diagnostic services ▪ family therapy ▪ opioid treatment • Outpatient hospital/outpatient behavioral health treatment facility charges for services including: ▪ Intensive Outpatient Programs (IOP) and related aftercare services • Inpatient health care professional charges • Inpatient hospital/residential behavioral health treatment facility charges • Outpatient health care professional lab and diagnostic imaging • Outpatient hospital/facility lab and diagnostic imaging • Inpatient health care professional lab and diagnostic imaging • Inpatient hospital/facility lab and diagnostic imaging	You pay nothing after deductible.	You pay 20% coinsurance after deductible.	You pay 40% coinsurance after deductible, plus you pay any charges billed to you that exceed the Allowed Amount.

NOTES:

- **Prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification are required. Please see the "Notification Requirements" section.**
- All eligible inpatient hospital/facility services combined are limited to 45 days per person per calendar year when you use an Out-of-Network Provider.
- All eligible inpatient professional services combined are limited to 45 days per person per calendar year when you use an Out-of-Network Provider.
- Court-ordered treatment for substance abuse care that is based on an evaluation and recommendation for such treatment or services by a physician or a licensed psychologist, a licensed alcohol and drug dependency counselor or a certified substance abuse assessor is deemed medically necessary.
- Court-ordered treatment for substance abuse care that is not based on an evaluation and recommendation as described above will be evaluated to determine medical necessity. Court-ordered treatment will be covered if it is determined to be medically necessary and otherwise covered under this contract.
- Outpatient family therapy is covered if part of a recommended treatment plan.
- Admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary for the entire hold.
- For home health related services, please refer to "Home Health Care."
- Coverage is provided for therapy conducted by televideo conferencing services. Eligible televideo conferencing services do not include email and physician/patient telephone consultations, except for eligible E-Visits.
- For medical stabilization during detoxification services billed by a facility, please refer to "Hospital Inpatient" or "Hospital Outpatient."

NOT COVERED:

- services for substance abuse or addictions that are not listed in the most recent edition of the *International Classification of Diseases*
- custodial care, nonskilled care, adult daycare or personal care attendants

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BEHAVIORAL HEALTH SUBSTANCE ABUSE CARE (continued)

NOT COVERED:

- services or confinements ordered by a court or law enforcement officer that are not medically necessary
- evaluations that are not performed for the purpose of diagnosing or treating substance abuse or addictions including, but not limited to: custody evaluations; parenting assessments; education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status, parental competency and domestic violence programs
- room and board for foster care, group homes, incarceration, shelter, shelter care, and lodging programs
- halfway house services
- substance abuse interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of a family member, friend or colleague, with the intent of convincing the affected person to enter treatment for the condition
- charges made by a healthcare professional for email and physician/patient telephone consultations, except for eligible E-Visits
- please refer to the "General Exclusions" section

GENERAL EXCLUSIONS

We do not pay for:

1. Treatment, services or supplies which are not medically necessary.

2. Charges for or related to care that is investigative, except for certain routine care for approved cancer clinical trials by approved investigators at qualified performance sites and approved by us in advance of treatment.

3. Any portion of a charge for a covered service or supply that exceeds the Allowed Amount, except as specified in the "Benefit Chart."

4. Services that are provided without charge, including services of the clergy.

5. Services performed before the effective date of coverage, and services received after your coverage terminates, even though your illness started while coverage was in force.

6. Services for or related to therapeutic acupuncture except for treatment of chronic pain (defined as a duration of at least six (6) months), or for the prevention and treatment of nausea associated with surgery, chemotherapy or pregnancy.

7. Services that are provided for the treatment of an employment related injury for which you are entitled to make a worker's compensation claim unless the worker's compensation carrier has disputed the claim.

8. Charges that are eligible, paid or payable under any medical payment automobile personal injury protection that is payable without regard to fault, including charges for services that are applied toward any deductible, copay, or coinsurance requirement of such a policy.

9. Services a provider gives to himself/herself or to a close relative (such as spouse, brother, sister, parent, grandparent, and/or child).

10. Services to treat injuries which occur while on military duty that are recognized by the Veteran's Administration as services related to service connected illness/injuries.

11. Treatment of preexisting conditions incurred during the preexisting condition limitation period.

12. Charges for services for dependents.

13. Services that are prohibited by law or regulation.

14. Services which are not within the scope of licensure or certification of a provider.

15. Charges for furnishing medical records or reports and associated delivery charges.

16. Travel, transportation, or living expenses, whether or not recommended by a physician, except as specified in the "Benefit Chart."

17. Services for or related to bariatric surgery.

18. Services for or related to transportation other than local ambulance service to the nearest medical facility equipped to treat the illness or injury, except as specified in the "Benefit Chart."

With Behavioral Health Care Coverage Option:

19. Services for or related to mental illness not listed in the most recent edition of the *International Classification of Diseases.*

20. Services for or related to intensive behavioral therapy programs for the treatment of autism spectrum disorders including, but not limited to: Intensive Early Intervention Behavioral Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas Therapy.

EXHIBIT 4

State: Minnesota **Filing Company:** Medica Insurance Company
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003C Small Group Only - PPO Standard
Product Name: 2011 MIC Mandated PP MN
Project Name/Number: 2011 MIC Mandated PP MN/MIC MAN PPMN (8/11)

Form Schedule

Lead Form Number: MIC MAN PPMN (8/11)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved 11/21/2011	2011 MIC Mandated PP MN	MIC MAN PPMN (8/11)	CER	Initial			2011 MIC Small Employer Mandated Plan Revised.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Medica Choice Passport

Certificate of Coverage

MEDICA®

[Group Name][1-100][0-100%][0-10,000][-][0-60]
[BPL [XXXXX]] [DOC] [PLAN [NAME][CODE]] [XXXXX]

L. *Mental Health*

This section describes coverage for services to diagnose and treat mental disorders listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders.*

See *Definitions.* These words have specific meanings: benefits, claim, coinsurance, copayment, custodial care, deductible, emergency, hospital, inpatient, medically necessary, member, mental disorder, network, non-network, non-network provider reimbursement amount, provider.

Prior authorization. For prior authorization requirements of *in-network* and *out-of-network benefits*, call Medica's designated mental health and substance abuse provider at 1-800-848-8327 or for Hearing Impaired members, please contact: National Relay Center 1-800-855-2880, then ask them to dial Medica Behavioral Health at 1-866-567-0550.

For purposes of this section:

1. Outpatient services include:
   a. Outpatient services for the diagnosis and treatment of certain mental disorders as listed in the International Classification of Diseases-Clinical Modification (ICD-9-CM), Seventh Edition-Codes 295-299, including:
      - Schizophrenic disorders
      - Episodic mood disorders
      - Paranoid states
      - Other non-organic psychoses
      - Psychoses with origin specific to childhood
   b. Outpatient services other than those described in 1.a. above, including:
      i. Diagnostic evaluations and psychological testing.
      ii. Psychotherapy and psychiatric services.
      iii. [Intensive outpatient programs, including day treatment, meaning time limited comprehensive treatment plans, which may include multiple services and modalities, delivered in an outpatient setting (up to 19 hours per week).]
      iv. Treatment for a minor, including family therapy.
      v. Treatment of serious or persistent disorders.
      vi. Diagnostic evaluation for attention deficit hyperactivity disorder (ADHD) or pervasive development disorders (PDD).
      vii. Services, care, or treatment described as benefits in this certificate and ordered by a court on the basis of a behavioral health care evaluation performed by a physician or licensed psychologist and that includes an individual treatment plan.

2. Inpatient services include inpatient services for the diagnosis and treatment of certain mental disorders as listed in the International Classification of Diseases-Clinical Modification (ICD-9-CM), Seventh Edition-Codes 295-299, including:
   - Schizophrenic disorders
   - Episodic mood disorders
   - Paranoid states
   - Other non-organic psychoses
   - Psychoses with origin specific to childhood

Covered

For benefits and the amounts you pay, see the table in this section.

- For *in-network benefits*:

  Medica's designated mental health and substance abuse provider arranges in-network mental health benefits. If you require hospitalization, Medica's designated mental health and substance abuse provider will refer you to one of its hospital providers (Medica and Medica's designated mental health and substance abuse provider hospital networks are different).

  For claims questions regarding *in-network benefits*, call Medica's designated mental health and substance abuse provider Customer Service at [1-866-214-6829].

- For *out-of-network benefits*:

  1. Mental health services from a non-network provider listed below will be eligible for coverage under out-of-network benefits provided that the health care professional or facility is licensed, certified, or otherwise qualified under state law to provide the mental health services and practice independently:
     a. Psychiatrist
     b. Psychologist
     c. Registered nurse certified as a clinical specialist or as a nurse practitioner in psychiatric and mental health nursing
     d. Mental health clinic
     e. Mental health residential treatment center
     f. Independent clinical social worker
     g. Marriage and family therapist
     h. Hospital that provides mental health services
  2. Emergency mental health services are eligible for coverage under in-network benefits.

  In addition to the deductible and coinsurance described for out-of-network benefits, you are responsible for any charges in excess of the non-network provider reimbursement amount. **The out-of-pocket maximum does not apply to these charges.** Please see *Important member information about out-of-network benefits* in *How To Access Your Benefits* for more information and an example calculation of out-of-pocket costs associated with out-of-network benefits.

Not covered

These services, supplies, and associated expenses are not covered:

1. Services for mental disorders not listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* or as listed in the *International Classification of Diseases-Clinical Modification (ICD-9-CM), Seventh Edition-Codes 295-299*, except as described in this section.
2. Services for a condition when there is no reasonable expectation that the condition will improve.
3. Services, care, or treatment that is not medically necessary, unless ordered by a court as specifically described in this section.
4. Relationship counseling.
5. Family counseling services, except as specifically described in this certificate as treatment for a minor.
6. Services for telephone psychotherapy.
7. Services beyond the initial evaluation to diagnose mental retardation or learning disabilities, as those conditions are defined in the current edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.
8. Services, including room and board charges, provided by health care professionals or facilities that are not appropriately licensed, certified, or otherwise qualified under state law to provide mental health services. This includes, but is not limited to, services provided by mental health providers who are not authorized under state law to practice independently, and services received from a halfway house, housing with support, therapeutic group home, boarding school, or ranch.
9. Services to assist in activities of daily living that do not seek to cure and are performed regularly as a part of a routine or schedule.
10. Room and board charges associated with mental health residential treatment services providing less than 30 hours a week per individual of mental health services, or lacking an on-site medical/psychiatric assessment within 48 hours of admission, psychiatric follow-up visits at least once per week, and 24-hour nursing coverage.

See *Exclusions* for additional services, supplies, and associated expenses that are not covered.

Your Benefits and the Amounts You Pay

Benefits	In-network benefits [after deductible]	* Out-of-network benefits [after deductible]

*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.**

1. Outpatient services	20% coinsurance [after a copayment of $15/visit]	50% coinsurance
a. Outpatient services for the diagnosis and treatment of certain mental disorders as listed in the International Classification of Diseases-Clinical Modification (ICD-9-CM) Seventh Edition-Codes 295-299, including: • Schizophrenic disorders • Affective psychoses • Paranoid states • Other organic psychoses • Psychoses with origin specific to childhood		
b. Outpatient services other than those described in item 1.a. above, including: i. Evaluations and diagnostic services ii. Therapeutic services including psychiatric services iii. Treatment for a minor, including family therapy iv. Treatment of serious or persistent disorders v. Diagnostic evaluation for attention deficit hyperactivity disorder (ADHD) or pervasive developmental disorder (PDD)	20% coinsurance [after a copayment of [$15/visit]	50% coinsurance

Your Benefits and the Amounts You Pay

Benefits	In-network benefits [after deductible]	* Out-of-network benefits [after deductible]

*** For out-of-network benefits, in addition to the deductible and coinsurance, you are responsible for any charges in excess of the non-network provider reimbursement amount. Additionally, these charges will not be applied toward satisfaction of the deductible or the out-of-pocket maximum.**

2. Inpatient hospital services for the diagnosis and treatment of certain mental disorders as listed in the *International Classification of Diseases-Clinical Modification (ICD-9-CM), Seventh Edition*- Codes 295-299, including: a. Schizophrenic disorders b. Episodic mood disorders c. Paranoid states d. Other non-organic psychoses e. Psychoses with origin specific to childhood	20% coinsurance [after a copayment of $300 per inpatient stay]	50% coinsurance

W. *Exclusions*

See *Definitions.* These words have specific meanings: claim, cosmetic, custodial care, durable medical equipment, emergency, investigative, medically necessary, member, non-network, physician, provider, reconstructive, routine foot care.

Medica will not provide coverage for any of the services, treatments, supplies, or items described in this section even if it is recommended or prescribed by a physician or it is the only available treatment for your condition.

This section describes additional exclusions to the services, supplies and associated expenses already listed as *Not covered* in this certificate. These include:

1. Services that are not medically necessary. This includes but is not limited to services inconsistent with the medical standards and accepted practice parameters of the community and services inappropriate—in terms of type, frequency, level, setting, and duration—to the diagnosis or condition.
2. Services or drugs used to treat conditions that are cosmetic in nature, unless otherwise determined to be reconstructive.
3. Refractive eye surgery, including but not limited to LASIK surgery.
4. The purchase, replacement, or repair of eyeglasses, eyeglass frames, or contact lenses when prescribed solely for vision correction, and their related fittings.
5. Services provided by an audiologist when not under the direction of a physician, air and bone conduction hearing aids (including internal, external, or implantable hearing aids or devices), and other devices to improve hearing, and their related fittings, except cochlear implants and related fittings and except as stated in *Durable Medical Equipment And Prosthetics.*
6. A drug, device, or medical treatment or procedure that is investigative.
7. Genetic testing when performed in the absence of symptoms or high risk factors for a heritable disease; genetic testing when knowledge of genetic status will not affect treatment decisions, frequency of screening for the disease, or reproductive choices; genetic testing that has been performed in response to direct to consumer marketing and not under the direction of your physician.
8. Services or supplies not directly related to care.
9. Autopsies.
10. Enteral feedings, unless they are the sole source of nutrition; however, enteral feedings of standard infant formulas, standard baby food, and regular grocery products used in blenderized formulas are excluded regardless of whether they are the sole source of nutrition.
11. Nutritional and electrolyte substances, except as specifically described in *Miscellaneous Medical Services And Supplies.*
12. Physical, occupational, or speech therapy or chiropractic services when there is no reasonable expectation that the condition will improve over a predictable period of time.
13. Reversal of voluntary sterilization.

Exclusions

38. Coverage for costs associated with translation of medical records and claims to English.
39. Treatment for spider veins.
40. Services not received from or under the direction of a physician, except as described in this certificate.
41. Coverage for voluntary sterilization or reversal of voluntary sterilization, except when medically necessary.
42. Implants for the purpose of contraception.
43. Orthognathic surgery.
44. Sensory integration, including auditory integration training.
45. Services for or related to vision therapy and orthoptic and/or pleoptic training, except as described in *Professional Services*.
46. Services for or related to intensive behavior therapy treatment programs for the treatment of autism spectrum disorders. Examples of such services include, but are not limited to, Intensive Early Intervention Behavior Therapy Services (IEIBTS), Intensive Behavioral Intervention (IBI), and Lovaas therapy.
47. Health care professional services for maternity labor and delivery in the home.
48. Telephone consultations.
49. Surgery for weight loss or morbid obesity, including initial procedures, surgical revisions, and subsequent procedures.
50. Services and supplies for or related to fertility testing, treatment of infertility, and conception by artificial means, including but not limited to: artificial insemination, in vitro fertilization, ovum or embryo placement or transfer, gamete and zygote intra-fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures.
51. Infertility drugs.
52. Hospice service.
53. Acupuncture.
54. Services solely for or related to the treatment of snoring.
55. Interpreter services.
56. Services provided to treat injuries or illness that are the result of committing a crime or attempting to commit a crime.
57. Services for private duty nursing, except as stated in *Home Health Care*. Examples of private duty nursing services include, but are not limited to, skilled or unskilled services provided by an independent nurse who is ordered by the member or the member's representative, and not under the direction of a physician.
58. Laboratory testing that has been performed in response to direct-to-consumer marketing and not under the direction of a physician.
59. Medical devices that are not approved by the U.S. Food and Drug Administration (FDA), other than those granted a humanitarian device exemption.
60. Scalp hair prosthesis or wigs.

EXHIBIT 5

(a), effective for the biennium beginning July 1, 2013, the commissioner of management and budget shall transfer $1,000,000 each fiscal year from the health access fund to the medical education and research costs fund established under section 62J.692, for distribution under section 62J.692, subdivision 4, paragraph (c).

Sec. 2. Minnesota Statutes 2012, section 43A.23, is amended by adding a subdivision to read:

Subd. 4. **Coverage for autism spectrum disorders.** For participants in the state employee group insurance program, the commissioner of management and budget must administer the identical benefit as is required under section 62A.3094.

EFFECTIVE DATE. This section is effective January 1, 2016, or the date a collective bargaining agreement or compensation plan that includes changes to this section is approved under Minnesota Statutes, section 3.855, whichever is earlier.

Sec. 3. **[62A.3094] COVERAGE FOR AUTISM SPECTRUM DISORDERS.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in paragraphs (b) to (d) have the meanings given.

(b) "Autism spectrum disorders" means the conditions as determined by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(c) "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's condition, and diagnostic testing and preventative services. Medically necessary care must be consistent with generally accepted practice parameters as determined by physicians and licensed psychologists who typically manage patients who have autism spectrum disorders.

(d) "Mental health professional" means a mental health professional as defined in section 245.4871, subdivision 27, clause (1), (2), (3), (4), or (6), who has training and expertise in autism spectrum disorder and child development.

Subd. 2. **Coverage required.** (a) A health plan issued to a large employer, as defined in section 62Q.18, subdivision 1, must provide coverage for the diagnosis, evaluation, multidisciplinary assessment, and medically necessary care of children under 18 with autism spectrum disorders, including but not limited to the following:

(1) early intensive behavioral and developmental therapy based in behavioral and developmental science, including, but not limited to, all types of applied behavior analysis, intensive early intervention behavior therapy, and intensive behavior intervention;

(2) neurodevelopmental and behavioral health treatments and management;

(3) speech therapy;

(4) occupational therapy;

(5) physical therapy; and

(6) medications.

(b) The diagnosis, evaluation, and assessment must include an assessment of the child's developmental skills, functional behavior, needs, and capacities.

(c) The coverage required under this subdivision must include treatment that is in accordance with an individualized treatment plan prescribed by the enrollee's treating physician or mental health professional.

(d) A health carrier may not refuse to renew or reissue, or otherwise terminate or restrict, coverage of an individual solely because the individual is diagnosed with an autism spectrum disorder.

(e) A health carrier may request an updated treatment plan only once every six months, unless the health carrier and the treating physician or mental health professional agree that a more frequent review is necessary due to emerging circumstances.

(g) An independent progress evaluation conducted by a mental health professional with expertise and training in autism spectrum disorder and child development must be completed to determine if progress toward function and generalizable gains, as determined in the treatment plan, is being made.

Subd. 3. **No effect on other law.** Nothing in this section limits the coverage required under section 62Q.47.

Subd. 4. **State health care programs.** This section does not affect benefits available under the medical assistance and MinnesotaCare programs and does not limit, restrict, or otherwise reduce coverage under these programs.

EFFECTIVE DATE. This section is effective for health plans offered, sold, issued, or renewed on or after January 1, 2014.

Sec. 4. Minnesota Statutes 2012, section 62J.692, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Accredited clinical training" means the clinical training provided by a medical education program that is accredited through an organization recognized by the Department of Education, the Centers for Medicare and Medicaid Services, or another national body who reviews the accrediting organizations for multiple disciplines and whose standards for recognizing accrediting organizations are reviewed and approved by the commissioner of health ~~in consultation with the Medical Education and Research Advisory Committee~~.

(b) "Commissioner" means the commissioner of health.

(c) "Clinical medical education program" means the accredited clinical training of physicians (medical students and residents), doctor of pharmacy practitioners, doctors of chiropractic, dentists, advanced practice nurses (clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), ~~and~~ physician assistants, dental therapists and advanced dental therapists, psychologists, clinical social workers, community paramedics, and community health workers.

(d) "Sponsoring institution" means a hospital, school, or consortium located in Minnesota that sponsors and maintains primary organizational and financial responsibility for a clinical medical education program in Minnesota and which is accountable to the accrediting body.