



Summary Plan Description

Duluth Joint Powers Enterprise Trust - Medical Benefit Plan 3A

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Summary Plan Description Effective Date: The later of January 1, 2013 and the Covered Person's effective date of coverage under the Plan.

HealthPartners NationalONESM Plan Network Schedule of Payments

See Sections III. and IV. of this SPD for additional information about covered services and limitations.

The amount that the Plan pays for covered services is listed below. The Covered Person is responsible for the specified dollar amount and/or percentage of charges that the Plan does not pay.

Coverage may vary according to your network or provider selection.

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

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

For covered services delivered by out-of-network providers, this 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 which the Plan considers 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. You must pay for any charges above the usual and customary charge, and they do not apply to the out-of-pocket limit.

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

Combined Day Limit: Your total benefit is combined for inpatient hospitalization, skilled nursing facility care services and inpatient behavioral health services, and limited to 365 days per period of confinement. Each day of such services provided under the Network Benefits and Out-of-Network Benefits counts toward this combined day limit, for the same period of confinement.

Copayment/Coinsurance: The specified dollar amount, or percentage, of charges incurred for covered services, which the Plan does not pay, but which a Covered Person must pay, each time a Covered Person receives certain medical services, procedures or items. The Plan's payment for those covered services or items begins after the copayment or coinsurance is satisfied. Covered services or items requiring a copayment or coinsurance are specified in this SPD.

For services provided by a network provider:
The amount which is listed as a percentage of charges or coinsurance is based on the network providers' discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule rate for case rate or withhold arrangements. However, if a network providers' discounted charge for a service or item is less than the flat dollar copayment, you will pay the network providers' discounted charge. A copayment or coinsurance is due at the time a service is provided, or when billed by the provider.

For services provided by an out-of-network provider:
Any copayment or coinsurance is applied to the lesser of the providers' charge or the usual and customary charge for a service.

The copayment or coinsurance applicable for a scheduled visit with a network provider will be collected for each visit, late cancellation and failed appointment.

Deductible: The specified dollar amount of charges incurred for covered services, which the Plan does not pay, but a Covered Person or a covered family has to pay first in a calendar year. The Plan's payment for those services or items begins after the deductible is satisfied. If you have a family deductible, each individual family member may only contribute up to the individual deductible amount toward the family deductible. An individual's copayments and coinsurance do not apply toward the family deductible. For network providers, the amount of charges that apply to the deductible are based on the network providers' discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule for case rate or withhold arrangements. For out-of-network providers, the amount of charges that apply to the deductible are the lesser of the providers' charges or the usual and customary charge for a service.

Deductible Carryover: Charges incurred in the last three months of a calendar year, which are applied to any deductible for that calendar year, are carried over and applied toward any deductible for the following calendar year. The deductible carryover amount does not apply to the out-of-pocket limit for the following calendar year.

Lifetime Maximum Benefit: The specified coverage limit paid for all Out-of-Network charges and actually paid for a Covered Person. Payment for Out-of-Network Benefits under the Plan ceases for that Covered Person when that limit is reached. The Covered Person has to pay for subsequent charges for Out-of-Network Benefits.

Out-of-Pocket Expenses: You pay the specified copayments/coinsurance and deductibles applicable for particular services, subject to the out-of-pocket limit described below. These amounts are in addition to employee contributions.

Out-of-Pocket Limit: You pay the copayments/coinsurance and deductibles for covered services, to the individual or family out-of-pocket limit. Thereafter, 100% of charges incurred are covered under the Plan for all other covered services for the rest of the calendar year. You pay amounts greater than the out-of-pocket limit if any benefit maximums are exceeded or if the lifetime maximum is exceeded.

Out-of-Network Benefits for bariatric surgery do not apply to the out-of-pocket limit and will not be paid at 100% once the out-of-pocket limit has been met.

Non-Network Benefits above the usual and customary charge (see definition of charge above) do not apply to the out-of-pocket limit.

The reduction in benefits for failure to comply with CareCheck[®] requirements will not apply toward the out-of-pocket limit.

You are responsible to keep track of the out-of-pocket expenses. Contact HealthPartners Member Services department for assistance in determining the amount paid by the Covered Person for specific eligible services received. Claims for reimbursement under the out-of-pocket limit provisions are subject to the same time limits and provisions described under the "Claims Procedures" section of the SPD.

FOR ELIGIBLE FAMILY MEMBERS OF A FREEDOM/NATIONAL PLAN ENROLLEE:

	<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
Combined Calendar Year Deductible	\$250	\$250

The deductibles under the Network Benefits and the Out-of-Network Benefits are combined.

Combined Calendar Year Out-of-Pocket Limit	\$1,250	\$1,250
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The out-of-pocket limits under the Network Benefits and the Out-of-Network Benefits are combined.

Out-of-Network Benefits for bariatric surgery do not apply to the out-of-pocket limit and will not be paid at 100% once the out-of-pocket limit has been met.

Non-Network Benefits above the usual and customary charge (see definition of charge above) do not apply to the out-of-pocket limit.

Any reduction in benefits for failure to comply with CareCheck[®] requirements will not apply toward the out-of-pocket limit.

FOR ALL OTHER COVERED PERSONS:

	<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
Individual Calendar Year Deductible	\$250	\$250
Family Calendar Year Deductible	\$500	\$500

The deductibles under the Network Benefits and the Out-of-Network Benefits are combined.

Individual Calendar Year Out-of-Pocket Limit	\$1,250	\$1,250
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Family Calendar Year Out-of-Pocket Limit	\$2,500	\$2,500
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The out-of-pocket limits under the Network Benefits and the Out-of-Network Benefits are combined.

Out-of-Network Benefits for bariatric surgery do not apply to the out-of-pocket limit and will not be paid at 100% once the out-of-pocket limit has been met.

Non-Network Benefits above the usual and customary charge (see definition of charge above) do not apply to the out-of-pocket limit.

Any reduction in benefits for failure to comply with CareCheck[®] requirements will not apply toward the out-of-pocket limit.

INDIVIDUAL LIFETIME MAXIMUM BENEFIT

Bariatric Surgery Lifetime Maximum Benefit Unlimited \$5,000

Any benefits applied to the Bariatric Surgery Lifetime Maximum Benefit shown above will also apply towards the Lifetime Maximum Benefit described below.

Lifetime Maximum Benefit Unlimited \$2,000,000

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

***Network Benefits**

***Out-of-Network Benefits**

YOU MAY BE REQUIRED TO GET PRE-CERTIFICATION BEFORE USING CERTAIN OUT-OF-NETWORK SERVICES. SEE I.F. "CARECHECK®" IN THIS SPD FOR SPECIFIC INFORMATION ABOUT PRE-CERTIFICATION.

A. ACUPUNCTURE	80% of the charges incurred.	80% of the charges incurred.
B. AMBULANCE AND MEDICAL TRANSPORTATION	80% of the charges incurred.	See Network Benefits.
C. BEHAVIORAL HEALTH SERVICES		
Mental Health Services		
a. Outpatient Services, including day treatment, group therapy and intensive outpatient services	80% of the charges incurred.	80% of the charges incurred.
b. Inpatient Services, including psychiatric treatment for emotionally handicapped children	80% of the charges incurred.	80% of the charges incurred.
	<i>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</i>	<i>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</i>
Chemical Health Services		
a. Outpatient Services, including day treatment and intensive outpatient services	80% of the charges incurred.	80% of the charges incurred.
	<i>The Plan covers supervised lodging at a contracted organization for Covered Persons actively involved in an affiliated licensed chemical dependency day treatment or intensive outpatient program for treatment of alcohol or drug abuse.</i>	
b. Inpatient Services	80% of the charges incurred.	80% of the charges incurred.
	<i>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</i>	<i>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</i>
D. CHIROPRACTIC SERVICES.	80% of the charges incurred.	80% of the charges incurred.

***Deductible must first be satisfied.**
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COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

	<u>*Network Benefits</u>	<u>*Out-of-Network Benefits</u>
E. DENTAL SERVICES		
Accidental Dental Services	80% of the charges incurred.	80% of the charges incurred.
	<i>For all accidental dental services, treatment and/or restoration must be initiated within six months of the date of the injury. Coverage is limited to the initial course of treatment and/or initial restoration. Services must be provided within 24 months of the date of injury to be covered.</i>	
Medical Referral Dental Services		
a. Medically Necessary Outpatient Dental Services	80% of the charges incurred.	80% of the charges incurred.
b. Medically Necessary Hospitalization and Anesthesia for Dental Care	80% of the charges incurred.	80% of the charges incurred.
	<i>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</i>	<i>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</i>
c. Medical Complications of Dental Care	80% of the charges incurred.	80% of the charges incurred.
Oral Surgery	80% of the charges incurred.	80% of the charges incurred.
Orthognathic Surgery Benefit	80% of the charges incurred.	80% of the charges incurred.
Treatment of Cleft Lip and Cleft Palate of a Dependent Child	80% of the charges incurred.	80% of the charges incurred.
Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD)	80% of the charges incurred.	80% of the charges incurred.
F. DIAGNOSTIC IMAGING SERVICES		
<i>The Plan covers services provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)</i>		
Associated with covered preventive services (MRI/CT procedures are not considered preventive)	Diagnostic imaging for preventive services is covered at the benefit level shown in the Preventive Services section.	
For illness or injury		
a. Outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT)	80% of the charges incurred.	80% of the charges incurred.
b. All other outpatient diagnostic imaging services	80% of the charges incurred.	80% of the charges incurred.

***Deductible must first be satisfied.**
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COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

	<u>*Network Benefits</u>	<u>*Out-of-Network Benefits</u>
G. DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES		
Custom molded foot orthotics and shoes (must be prescribed by a physician)	80% of the charges incurred.	80% of the charges incurred.
Special dietary treatment for Phenylketonuria (PKU)	80% of the charges incurred. Deductible does not apply.	80% of the charges incurred.
Oral amino acid based elemental formula if it meets HealthPartners medical coverage criteria	80% of the charges incurred.	80% of the charges incurred.
Wigs for alopecia areata	80% of the charges incurred. Deductible does not apply.	80% of the charges incurred. Deductible does not apply.
	<i>Wigs for hair loss resulting from alopecia areata are subject to \$350 maximum benefit per calendar year for Network Benefits and Out-of-Network Benefits combined.</i>	
All other durable medical equipment, prosthetics, orthotics and supplies	80% of the charges incurred.	80% of the charges incurred.
	<i>Compression support stockings are limited to 8 pairs per calendar year.</i>	
H. EMERGENCY AND URGENTLY NEEDED CARE SERVICES		
Urgently Needed care provided at clinics	80% of the charges incurred.	80% of the charges incurred.
Emergency care in a hospital emergency room, including professional services of a physician	80% of the charges incurred.	80% of the charges incurred. Usual and customary provision does not apply.
Inpatient emergency care in a hospital	80% of the charges incurred.	80% of the charges incurred. Usual and customary provision does not apply.
	<i>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</i>	<i>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</i>
	<i>Out-of-Network professional fees will be paid at the Network Inpatient Hospital Services Benefit level if the Covered Person is admitted inpatient to a network hospital through the emergency room.</i>	

***Deductible must first be satisfied.**
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COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

	<u>*Network Benefits</u>	<u>*Out-of-Network Benefits</u>
I. HEALTH EDUCATION	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.
J. HOME HEALTH SERVICES		
Physical therapy, occupational therapy, speech therapy, respiratory therapy, home health aide services and palliative care	80% of the charges incurred.	80% of the charges incurred.
TPN/IV therapy, skilled nursing services, prenatal and postnatal services, child health services and phototherapy	80% of the charges incurred.	80% of the charges incurred.
K. HOME HOSPICE SERVICES	80% of the charges incurred.	80% of the charges incurred.
	<i>Respite care is limited to 5 days per episode, and respite care and continuous care combined are limited to 30 days.</i>	
L. HOSPITAL AND SKILLED NURSING FACILITY SERVICES		
Medical or Surgical Hospital Services		
a. Inpatient Hospital Services	80% of the charges incurred.	80% of the charges incurred.
	<i>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</i>	<i>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</i>
	<i>Each Covered Person's admission or confinement, including that of a newborn child, is separate and distinct from the admission or confinement of any other Covered Person.</i>	
b. Outpatient Hospital, Ambulatory Care or Surgical Facility Services (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)	80% of the charges incurred.	80% of the charges incurred.
Skilled Nursing Facility Care	80% of the charges incurred.	80% of the charges incurred.
	<i>Limited to 120 day maximum per period of confinement, subject to the combined day limit.</i>	<i>Limited to 120 day maximum per period of confinement, subject to the combined day limit.</i>
	<i>Each day of services provided under the Network Benefits and Out-of-Network Benefits, combined, counts toward the maximums shown above.</i>	

***Deductible must first be satisfied.**
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COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

	<u>*Network Benefits</u>	<u>*Out-of-Network Benefits</u>
M. LABORATORY SERVICES		
<i>The Plan covers services provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)</i>		
Associated with covered preventive services	Laboratory for preventive services is covered at the benefit level shown in the Preventive Services section.	
For illness or injury	80% of the charges incurred.	80% of the charges incurred.
N. MASTECTOMY RECONSTRUCTION BENEFIT		
	Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Out-of-Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.
O. OFFICE VISITS FOR ILLNESS OR INJURY		
Office visits	80% of the charges incurred.	80% of the charges incurred.
Convenience clinics	80% of the charges incurred. Deductible does not apply.	80% of the charges incurred. Deductible does not apply.
Scheduled telephone visits	80% of the charges incurred. Deductible does not apply.	80% of the charges incurred. Deductible does not apply.
E-visits	80% of the charges incurred. Deductible does not apply.	80% of the charges incurred. Deductible does not apply.
Injections administered in a physician's office		
Allergy injections	80% of the charges incurred.	80% of the charges incurred.
All other injections	80% of the charges incurred.	80% of the charges incurred.

***Deductible must first be satisfied.**
25077-CON-900.18 SIN1-13

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

***Network Benefits**

***Out-of-Network Benefits**

P. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY

The Plan covers services provided in a clinic. The Plan also covers physical therapy provided in an outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)

Rehabilitative therapy

80% of the charges incurred.

80% of the charges incurred.

Physical, Occupational and Speech therapy combined are limited to 15 visits per calendar year.

Habilitative therapy

80% of the charges incurred.

80% of the charges incurred.

Physical, Occupational and Speech therapy combined are limited to 15 visits per calendar year.

Q. PRESCRIPTION DRUG SERVICES

ClearScript administers prescription drug services. For more information regarding this vendor, please contact your employer.

Benefits for all outpatient prescription drugs and other pharmacy items, including but not limited to glucose monitors, diabetic supplies, growth hormone, blood products and blood derivatives are administered by another vendor. The benefits described in this Summary Plan Description only cover prescription drugs which are administered during an office visit, an emergency room or urgent care visit, an outpatient hospital visit or an inpatient stay.

R. PREVENTIVE SERVICES

1. Routine health exams and periodic health assessments

100% of the charges incurred. Deductible does not apply.

100% of the charges incurred. Deductible does not apply.

2. Well child care

100% of the charges incurred. Deductible does not apply.

100% of the charges incurred. Deductible does not apply.

3. Routine prenatal services

100% of the charges incurred. Deductible does not apply.

100% of the charges incurred. Deductible does not apply.

4. Routine postnatal services

100% of the charges incurred. Deductible does not apply.

100% of the charges incurred. Deductible does not apply.

***Deductible must first be satisfied.**
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COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

	<u>*Network Benefits</u>	<u>*Out-of-Network Benefits</u>
5. Routine screening procedures for cancer	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.
6. Routine eye exams and contact lens fittings	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.
7. Routine hearing exams	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.
8. Professional voluntary family planning services	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.
9. Immunizations	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.
10. Women's preventive health services	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.
S. SPECIFIED OUT-OF-NETWORK SERVICES	Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury.	See Network Benefits for the services covered.
T. TRANSPLANT SERVICES	80% of the charges incurred. <i>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</i>	No coverage.
U. WEIGHT LOSS SURGERY OR BARIATRIC SURGERY	Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Out-of-Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

***Deductible must first be satisfied.**
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SPECIFIC INFORMATION ABOUT THE PLAN

Employer:	Duluth Joint Powers Enterprise Trust (A trust agreement with the City of Duluth, Duluth Airport Authority, Duluth Entertainment and Convention Center and the Housing Redevelopment Authority.)
Name of the Plan:	The Plan shall be known as the Duluth Joint Powers Enterprise Trust Comprehensive Hospital Medical Benefit Plan 3A which provides employee, retiree and dependent medical benefits
Address of the Plan:	402 City Hall 411 West First Street Duluth, MN 55802 218-730-5201
Group Number:	25077
Plan Year:	The period beginning on each January 1 in which the provisions of the Plan are in effect.
Plan Fiscal Year Ends:	December 31
Plan Sponsor: (is ultimately responsible for the management of the Plan; may employ or contract with persons or firms to perform day-to-day functions such as processing claims and performing other Plan-connected services.)	Duluth Joint Powers Enterprise Trust
Agent for Service of Legal Process:	General Counsel for Duluth Joint Powers Enterprise Trust
Named Fiduciary: (has the authority to control and manage the operation and administration of the Plan; has discretionary authority to determine eligibility for benefits or to construe the terms of the Plan.)	For purposes of determining eligibility and enrollment, and for funding claims paid and all related activities and responsibilities under the Plan, Duluth Joint Powers Enterprise Trust is the named fiduciary. Solely for purposes of determining coverage of claims, HealthPartners Administrators, Inc. is the named fiduciary.
Funding:	Claims are paid from the Duluth Joint Powers Enterprise Trust.
Plan Manager: (provides administrative services to the Plan Sponsor in connection with the operation of the Plan, such as processing of claims and other functions, as may be delegated to it.)	HealthPartners Administrators, Inc. 8170 33 rd Avenue South P.O. Box 1309 Minneapolis, MN 55440-1309 952-883-6000
Network Providers:	NationalONE SM Network
Contributions:	Please refer to the most recent enrollment material for information regarding contributions to your Plan which is hereby incorporated by this reference.

HEALTHPARTNERS MISSION

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

ABOUT HEALTHPARTNERS and YOUR EMPLOYER

HealthPartners Administrators, Inc. ("HPAI"). HPAI ("Plan Manager") is a third party administrator (TPA) which is a related organization of HealthPartners, Inc.

HealthPartners, Inc. ("HealthPartners"). HealthPartners is a Minnesota non-profit corporation and managed care organization.

Employer/The Trust ("Plan Sponsor"). The Employer/Trust has established a Medical Benefit Plan ("the Plan") to provide medical benefits for Subscribers and their Covered Dependents ("Covered Persons"). The Plan is "self-insured" which means that the Plan Sponsor pays the claims from its own funding as expenses for covered services as they are incurred. The Plan is described in the Summary Plan Description ("SPD"). The Plan Sponsor has contracted with HPAI to provide access to its network of health care providers, claims processing, pre-certification and other Plan administration services. However, the Plan Sponsor is solely responsible for payment of your eligible claims.

Powers of the Plan Sponsor. The Plan Sponsor shall have all powers and discretion necessary to administer the Plan, including, without limitation, powers to: (1) establish and revise the method of accounting for the Plan; (2) establish rules and prescribe any forms required for administration of the Plan; (3) change the Plan; and (4) terminate the Plan.

The Plan Sponsor, by action of an authorized officer or committee, reserves the right to change the Plan. This includes, but is not limited to, changes to contributions, deductibles, copayments, out-of-pocket maximums, benefits payable and any other terms or conditions of the Plan. The Plan Sponsor's decision to change the Plan may be due to changes in applicable laws or for any other reason. The Plan may be changed to transfer the Plan's liabilities to another plan or split the Plan into two or more parts.

The Plan Sponsor shall have the power to delegate specific duties and responsibilities. Any delegation by the Plan Sponsor may allow further delegations by such individuals or entities to whom the delegation has been made. Any delegation may be rescinded by the Plan Sponsor at any time. Each person or entity to whom a duty or responsibility has been delegated shall be responsible for only those duties or responsibilities, and shall not be responsible for any act or failure to act of any other individual or entity.

No Guarantee of Employment. The adoption and maintenance of the Plan shall not be deemed to be a contract of employment between the Plan Sponsor and any Subscriber. Nothing contained herein shall give any Subscriber the right to be retained in the employ of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge any Subscriber, any time, nor shall it give the Plan Sponsor the right to require any Subscriber to remain in its employ or to interfere with the Subscriber's right to terminate his or her employment at any time.

HealthPartners Trademarks. HealthPartners names and logos and all related products and service names, design marks and slogans are the trademarks of HealthPartners or its related companies.

I. INTRODUCTION TO THE SUMMARY PLAN DESCRIPTION

A. SUMMARY PLAN DESCRIPTION ("SPD")

This SPD, along with the Plan Manager's medical coverage criteria (available by logging onto your "myHealthPartners" account at www.healthpartners.com or by calling Member Services), is your description of the Employer's Medical Benefit Plan ("the Plan"). It describes the Plan's benefits and limitations. Included in this SPD is a Schedule of Payments which states the amount payable for the covered services. Amendments which we include with this SPD or send you at a later date are fully made a part of this SPD.

This SPD should be read completely. Many of its provisions are interrelated; reading just one or two provisions may give you incomplete information regarding your rights and responsibilities under the Plan. Many of the terms used in this SPD have special meanings and are specifically defined in the SPD. Your SPD should be kept in a safe place for your future reference.

The Plan is maintained exclusively for Subscribers and their Covered Dependents. Each Covered Person's rights under the Plan are legally enforceable. You may not assign or in any way transfer your rights under the Plan.

B. MEDICAL ADMINISTRATIVE SERVICES AGREEMENT ("ASA")

This SPD, together with the ASA between the Plan Sponsor and HPAI, as well as any amendments and any other documents referenced in the ASA, constitute the entire agreement between HPAI and the Plan Sponsor. The ASA is available for inspection at your Employer's office or at HealthPartners home office, at 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

C. CONFLICT WITH EXISTING LAW

In the event that any provision of this SPD is in conflict with applicable law, that provision only is hereby amended to conform to the minimum requirements of the law.

D. IDENTIFICATION CARD

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

E. HOW TO USE THE NETWORK

This SPD describes your covered services and how to obtain them. **The Plan provides Network Benefits and Out-of-Network Benefits from which you may choose to receive covered services.** Coverage may vary according to your network or provider selection. The provisions below contain information you need to know in order to obtain covered services.

Designated Physician, Provider, Facility or Vendor. This is a current list of network physicians, providers, facilities, or vendors which are authorized to provide certain covered services as described in this SPD. Call Member Services or visit www.healthpartners.com for a current list.

Network Providers. This is any one of the participating licensed physicians, dentists, mental and chemical health or other health care providers, facilities and pharmacies, which have entered into an agreement to provide health care services to Covered Persons.

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

ABOUT THE NETWORK

To obtain Network Benefits for covered services, you must select and receive services from Network Providers. If you are directed or referred by a Network Provider to an Out-of-Network Provider, covered services will be paid at the Out-of-Network Benefits level.

Network. This is the network of participating network providers.

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

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. Occasionally, HealthPartners may, in its sole discretion, apply a previous carrier's approach to coverage for a limited period of time to accommodate a member's specific needs for continuity of care when an employer is moving from another carrier to HealthPartners coverage.

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

Your physician may be required to obtain prior authorization for certain services. Your physician will coordinate the authorization process for any services which must first be authorized. You may call the Member Services Department or check on-line by logging onto your "myHealthPartners" account at www.healthpartners.com for a list of which services require your physician to obtain prior authorization.

HealthPartners medical or dental directors, or their designees, will determine medical necessity and appropriateness of certain treatments based on established medical policies, which are subject to periodic review and modification.

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.

You must use a designated convenience care clinic to obtain the convenience care benefit. You may call the Member Services Department or check on-line by logging onto your "myHealthPartners" account at www.healthpartners.com for a list.

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

For Network Benefits, non-emergency, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) must be provided at a designated facility.

To receive Network Benefits, weight loss surgery must be provided by a designated physician.

Multidisciplinary pain management must be provided at designated facilities.

Psychiatric residential treatment for emotionally handicapped children must be provided at designated facilities.

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

Second Opinions for Network Services. If you question a decision or recommendation about medical care, the Plan covers a second opinion from an appropriate network provider.

Prescription Drugs and Medical Equipment. Enrolling in the Plan does not guarantee that any particular prescription drug which is administered during an office visit, an emergency room or urgent care visit, an outpatient hospital visit or an inpatient stay will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment was available previously.

F. CARECHECK[®]

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 maximum coverage available to you under the Plan. You can designate another person to contact CareCheck[®] for you.

1. **CARECHECK[®] Services.** CareCheck[®] is HealthPartners utilization review program for out-of-network services. CareCheck[®] must pre-certify 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 pre-certification are scheduled, but not less than 48 hours 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 10 days of the decision.
3. **Failure to Comply with CareCheck[®] Requirements.** If you fail to make a request for pre-certification of services in the time noted above, but your services requiring pre-certification are subsequently approved as medically necessary, we will reduce the eligible charges by 15%.
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 SPD. CareCheck[®] only certifies medical necessity.
5. **Information Needed When You Call CareCheck[®].**

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

- the Covered Person's name, address, phone number, birth date and ID number;
- the attending physician's name, address, and phone number;
- the facility's name, address, and phone number;
- the reason for the services requiring review, as shown in a. above.

6. Pre-certification Process.

When a pre-certification for a non-urgent service is requested from HealthPartners, an initial determination must be made within 15 calendar days. This time period may be extended for an additional 15 calendar days, provided that the Plan Manager determines that such extension is necessary due to matters beyond the control of the Plan. If such extension is necessary, you will be notified prior to the expiration of the initial 15-day period.

When a pre-certification for an urgent service is requested from HealthPartners, an initial determination must be made within 72 hours, so long as all information reasonably needed to make a decision has been provided. In the event that the claimant has not provided all information necessary to make a decision, the claimant will be notified of such failure within 24 hours. The claimant will then be given 48 hours to provide the requested information. The claimant will be notified of the benefit determination within 48 hours after the earlier of HealthPartners receipt of the complete information or the end of the time granted to the claimant to provide the specified additional information.

How to contact CareCheck®: You may call **952-883-6400** in the Minneapolis/St. Paul metro area, **or 800-316-9807** (toll-free) 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.

G. ELIGIBILITY

Eligible Employees

All regular full time and part time active employees of the Duluth Joint Powers Enterprise Trust as defined in the bargaining agreements are eligible as specified in the Plan.

The following regular full-time active employees, appointed by the Duluth Joint Powers Enterprise Trust in the Legislative and Executive group, are eligible as specified in the Plan: City Attorney, Chief Administrative Officer, Community Relations Officer and the Mayor. Additionally, employees who are awarded Long-Term Disability benefits in the collective bargaining agreements are eligible Plan members.

The effective date of coverage under this Plan is outlined in the Basic, CDSA, Confidential, Fire, LELS and Police bargaining agreements with the Employer. You must comply with requests made by the Employer and/or the Plan Manager to substantiate eligibility requirements of Plan participation. Your coverage under the Plan will be terminated for failure to provide requested information. Additionally, you are obligated to inform the Employer immediately of changes or events impacting eligibility in the Plan (e.g., divorce, death, etc.).

The respective bargaining agreements for the following entities will outline benefit plan eligibility, the waiting period, and effective date of coverage:

1. Duluth Airport Authority;
2. Duluth Entertainment Convention Center (DECC); and
3. Housing and Redevelopment Authority of Duluth (HRA).

This Plan covers only those employees who work in the United States or its Territories. Employees who work and reside in foreign countries are not eligible for coverage. Employees who are U.S. citizens or permanent residents of the U.S. working outside of the U.S. on a temporary basis are eligible.

Eligible Retirees

Retirees must contact the Plan Sponsor for eligibility requirements. You must comply with requests made by the Employer and/or the Plan Manager to substantiate eligibility requirements of Plan participation. Your coverage under the Plan will be terminated for failure to provide requested information or for not making timely premium payments. Additionally, you are obligated to inform the Employer immediately of changes or events impacting eligibility in the Plan (e.g., divorce, death, etc.).

Eligible Dependents of Active or former Employees

NOTE: If both you and your spouse are employees or retirees of the employer, DECC, HRA, or Airport you may be covered as either an employee/retiree or as a dependent, or both. Your eligible dependent children may be covered under either parent's coverage, or both.

You must comply with requests made by the Employer and/or the Plan Manager to substantiate eligibility requirements of Plan participation. Your coverage under the Plan will be terminated for failure to provide requested information. Additionally, you are obligated to inform the Employer immediately of changes or events impacting eligibility in the Plan (e.g., divorce, death, etc.).

Spouse

Married spouse, meaning legally married opposite gender spouse.

Dependent Children

1. Unmarried natural-born dependent children to age 26.
2. Unmarried legally adopted children and children placed with you for legal adoption to age 26. Date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support.
3. Unmarried stepchildren to age 26.
4. Unmarried dependent children for whom you or your spouse have been appointed legal guardian to age 26.
5. Unmarried grandchildren to age 26 who live with you continuously from birth and are financially dependent upon you.
6. Unmarried children of the employee who are required to be covered by reason of a Qualified Medical Child Support Order (QMCSO), as defined in Minnesota Statute §518.171. The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You and your dependents can obtain, without charge, a copy of such procedures from the Plan Sponsor.

Disabled Dependents

1. Unmarried disabled dependent children who reach the limiting age while covered under this Plan if all of the following apply:
 - a. primarily dependent upon you;
 - b. are incapable of self-sustaining employment because of physical disability, mental retardation, mental illness, or mental disorders;
 - c. for whom application for extended coverage as a disabled dependent child is made within 31 days after reaching the age limit. After this initial proof, the Plan Manager may request proof again two (2) years later, and each year thereafter; and
 - d. must have become disabled prior to reaching limiting age.
2. Disabled dependents if both of the following apply:
 - a. incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and
 - b. chiefly dependent upon you for support and maintenance.

H. EFFECTIVE DATE OF COVERAGE

Coverage for you or your eligible dependents who were eligible on the effective date of the Plan will take effect on that date.

Adding New Employees

1. If the Plan Sponsor receives your application within 31 days after you become eligible, coverage for you and your eligible dependents starts on the first of the month following the date of eligibility. If the collective bargaining agreement (CBA) language differs, the effective date shall be governed by the CBA in force at the time of eligibility.
2. If the Plan Sponsor receives your application more than 31 days after you become eligible, you and your eligible dependents must reapply for coverage at the next annual open enrollment unless you meet the requirements of the special enrollment period.

Adding New Dependents

The section outlines the time period for application and the date coverage starts.

Adding spouse and/or stepchildren

1. If the Plan Sponsor receives the application within 31 days of the date of marriage, coverage for your spouse and/or stepchildren will be provided on the date your dependent(s) become eligible.
2. If the Plan Sponsor receives the application more than 31 days after the date of marriage, your spouse and/or stepchildren must reapply for coverage at the next annual open enrollment unless your spouse and/or stepchildren meet the requirements of the special enrollment period.

Adding newborns and children placed for adoption

The Plan Sponsor requests that you submit written application to add your newborn child or newborn grandchild within 31 days of the date of birth. Coverage for your newborn child or newborn grandchild starts on the date of birth.

The Plan Sponsor requests that you submit written application to add your adopted child within 31 days of the date of placement. Coverage for your adopted child starts on the date of placement.

Adding disabled children or disabled dependents

A disabled dependent may be added to the Plan if the disabled dependent is otherwise eligible under the Plan. Coverage starts the first of the month following the day the Plan Sponsor receives the application.

I. CHANGING PLAN COVERAGE

Eligible employees and retirees may add or delete dependents if they have a life qualifying event. The life qualifying events recognized by the Employer are:

1. adoption of a child;
2. birth of a child;
3. death of an employee or family member;
4. divorce;
5. employee change in employment status;
6. marriage;
7. Employee Open Enrollment (this event is applicable only to Employee annual open enrollment as specified by the Employer or a mid-year open enrollment specified by the Employer in the event of a contract settlement offering substantial benefit changes. Retirees do not participate in any open enrollment activities through the Duluth Joint Powers Enterprise Trust.);
8. spouse change in employment; or
9. unpaid leave of absence or Family Medical Leave (FMLA) taken by the employee or spouse.

J. SPECIAL ENROLLMENT PERIODS

Special enrollment periods are periods when an eligible employee or dependents may enroll in the Plan under certain circumstances **after they were first eligible for coverage**. The eligible circumstances are: 1.) a loss of other group health plan coverage; 2.) loss of Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP) coverage; 3.) eligibility for premium assistance; or 4.) acquiring a new dependent. The request for enrollment must be within 31 days (unless otherwise noted) of the eligible circumstances.

Newborns, newborn grandchildren, and children placed for adoption are eligible as of the date of birth, adoption, or placement for adoption – See Eligible Dependents in the Eligibility section.

1. Loss of Group Health Plan Coverage

Employees or dependents who are eligible but not enrolled in the Plan may enroll for coverage under this Plan as special enrollees upon the loss of other health plan coverage if all of the following conditions are met:

- a. the employee or dependent was covered under a group health plan or other health insurance coverage at the time coverage was previously offered to the employee or dependent;
- b. the employee must complete any required written waiver of coverage and state in writing that, at such time, other health insurance coverage was the reason for declining enrollment;
- c. the employee's or dependent's coverage is terminated because his/her COBRA continuation has been exhausted (not due to failure to pay the premium or for cause), he/she is no longer eligible for the Plan due to legal separation, divorce, death of the employee, termination of employment, reduction in hours, cessation of dependent status, all employer contributions towards the coverage were terminated, the individual no longer lives or works in an HMO service area; and
- d. the employee or dependent requested enrollment not later than 31 days after the termination of coverage or employer contribution.

Coverage is effective the day after the termination of prior coverage.

2. Loss of Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP) Coverage

Employees or dependents who are eligible but not enrolled in the Plan may enroll for coverage under this Plan as special enrollees upon the loss of Medicaid or CHIP coverage if all the following conditions are met:

- a. the employee or dependent was covered under Medicaid or CHIP at the time coverage was previously offered to the employee or dependent;
- b. the employee must complete any required written waiver of coverage and state in writing that, at such time, Medicaid or CHIP coverage was the reason for declining enrollment; and
- c. the employee or dependent must request enrollment no later than 60 days after the termination of Medicaid or CHIP coverage.

3. Eligibility for Premium Assistance

Employees or dependents who are eligible, but not enrolled in the Plan, may enroll for coverage under this Plan as special enrollees upon becoming eligible for premium assistance through the Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP) if all the following conditions are met:

- a. the employer must submit any required documentation indicating that the employee and/or dependents are eligible for premium assistance through Medicaid or CHIP; and
- b. the employee or dependent must request enrollment no later than 60 days after becoming eligible for premium assistance through Medicaid or CHIP.

4. Acquiring a New Dependent

Eligible employees who are either enrolled or not enrolled in the Plan may enroll themselves and newly acquired dependents for coverage under this Plan as special enrollees. If the employee is eligible under the terms of the Plan, the employee and eligible dependent are eligible for special enrollment when the employee acquires a new dependent through marriage, birth, adoption or placement for adoption.

Coverage is effective on the date of marriage, birth, adoption or placement for adoption, if application is received within 31 days after the marriage, birth, adoption or placement for adoption.

Dependent children other than the newly acquired dependent are not eligible for the special enrollment period.

K. TERMINATION EVENTS

Coverage ends on the earliest of the following dates:

1. For you and your dependents, the date on which the Plan terminates.
2. For you and your dependents, the last day of the month during which:
 - a. required charges for coverage were paid, if payment is not received when due. Your payment of charges to the employer does not guarantee coverage unless the Plan Manager receives full payment when due. If the Plan Manager terminates coverage for all employees in the Plan for nonpayment of the charges, the Plan Manager will give all employees a 30 day notice of termination prior to the effective date of cancellation using a list of addresses which is updated every 12 months.
 - b. you are no longer eligible.
 - c. you enter military services for duty lasting more than 31 days.
3. For the spouse, the date the spouse is no longer eligible for coverage. This is the last day of the month during which the employee and spouse divorce.
4. For a dependent child, the date the dependent child is no longer eligible for coverage. This is the last day of the month during which:
 - a. a covered stepchild is no longer eligible because the employee and spouse divorce;
 - b. the dependent child marries or reaches the dependent-child age limit;
 - c. the dependent child becomes covered as an employee under any health coverage plan sponsored by the employer;

- d. the disabled dependent is no longer eligible; or
- e. the dependent grandchild is no longer eligible.

To the extent that a termination would be considered a rescission under federal law under terms 2.b., 3 and 4. above, the Plan Sponsor is required to give the Covered Person 30 days advance notice of termination.

L. ACCESS TO RECORDS AND CONFIDENTIALITY

The Plan Sponsor complies with applicable state and federal laws governing the confidentiality and use of protected health information and medical records. As part of this Summary Plan Description, the Plan Sponsor is authorized to have access to and use protected health information held by any health care provider who delivers health care services to you under this Summary Plan Description. The Plan Sponsor is also allowed to use your protected health information when necessary, for: certain health care operations including, but not limited to: claims processing, including claims made 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, the evaluation of potential or actual claims against the Plan Sponsor, auditing and legal services, and other access and use without further authorization if permitted or required by another law.

In the event that protected health information is disclosed to the Plan Sponsor, the Plan Sponsor may only use or disclose such information as permitted by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and regulations promulgated thereunder and as amended including, certain Plan administrative functions such as: claims review, subrogation, quality assurance, auditing, monitoring and management of carve out plans. Information may only be disclosed to the Plan Sponsor upon receipt, by the Plan, of a certification from the Plan Sponsor to the amendment of the Plan documents and that your Plan Sponsor agrees to:

- Not use or further disclose information except as listed above or as required or permitted by law;
- Ensure that any agents or subcontractors agree to the same restrictions and conditions that apply to your Employer or Plan Sponsor and that such agents and subcontractors agree to implement reasonable and appropriate security measures to protect electronic protected health information;
- Not use or disclose any information for employment – related actions or decisions;
- Not use or disclose any information in connection with any other employee benefit plan of your Employer or Plan Sponsor;
- Report to the Plan any security incident it becomes aware of and any use or disclosure of the information that is inconsistent with the uses or disclosures described above;
- Make information available to fulfill your right to access your protected health information;
- Make the information available for amendment or to incorporate applicable amendments;
- Make the information available in order to provide an accounting of disclosures;
- Make its internal practices, books and records relating to the use and disclosure of information received from the Plan available to the Department of Human Services to determine compliance with HIPAA;
- Return or destroy all protected health information received from the Plan, if feasible, when use or disclosure is no longer required. If return or destruction is not possible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- Ensure only certain classes of employees designated by your Employer are permitted access to your protected health information for Plan administration functions;
- Implement an effective mechanism for handling noncompliance by the employees designated access to your protected health information;
- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic protected health information that is created, received, maintained or transmitted on behalf of the group health plan;
- Ensure adequate separation between the Plan and your Plan Sponsor is supported by reasonable and appropriate security measures.

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

HIPAA rules require Plan Sponsors to send Certificates of Coverage (also referred to as “HIPAA Certs” or “Certs”) to all individuals currently or previously covered under their medical plan. The Plan Sponsor may elect to send their own or have their third party administrator/Plan Manager (HPAI) send Certificates of Coverage.

Certificates of Coverage are documents that provide evidence of your prior or current medical coverage. Certificates of Coverage reflect the length of continuous medical coverage that you had under the Plan Sponsors’ Plan.

When your medical coverage is terminated, you will automatically be sent a Certificate of Coverage. You will also be sent a Certificate of Coverage anytime you request one. If you request a Certificate of Coverage while you have active medical coverage under the Plan, your Certificate of Coverage will indicate that your coverage is 'continuing'. You may request a Certificate of Coverage by calling Member Services phone number or writing to the address printed on your identification card.

According to HIPAA rules, Plan Sponsors must produce original Certificates of Coverage for a minimum of 24 months after the date that your medical coverage under the Plan Sponsors’ Plan terminates.

II. DEFINITIONS OF TERMS USED

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 benefits, as covered under the Out-of-Network Benefits of the Plan.

CareLineSM Service. This is a 24-hour telephone service which employs a staff of registered nurses who are available by phone to assist Covered Persons in assessing their need for medical care, and to coordinate after-hours care, as covered under the Plan.

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 medical services are approved only for limited use, under specific circumstances, as more fully described in this SPD.

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 Dependent. This is the eligible dependent enrolled in the Plan.

Covered Person. This is the eligible and enrolled employee and each of his or her eligible and enrolled dependents covered for benefits under the Plan. When used in this SPD, "you" or "your" has the same meaning as Covered Person.

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

Custodial Care. This is a supportive service 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 Covered Person's general medical condition must permit the necessary procedure(s).

Dentist. A duly licensed doctor of dental surgery or dental medicine, lawfully performing a dental service in accordance with governmental licensing privileges and limitations.

Eligible Dependents. These are the persons shown in section I.G. Eligibility.

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

Enrollment Date. This means the first day of coverage under the health benefit plan or the first day of the waiting period, if earlier.

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

Fiduciary. The person or organization that has the authority to control and manage the operation and administration of the Plan. The fiduciary has discretionary authority to determine eligibility for benefits and to construe the terms of the Plan.

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 Covered Person's maximum potential ability. The determination of whether such measurable progress has been made is within the sole discretion of the Plan's medical director or his or her designee, based on objective documentation.

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 Covered Persons as covered under the Plan.

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 under the Plan. 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. The Plan covers a semi-private room, unless a physician recommends that a private room is medically necessary. In the event a Covered Person chooses to receive care in a private room under circumstances in which it is not medically necessary, payment under the Plan toward the cost of the room shall be based on the average semi-private room rate in that facility.

Investigative. As determined by HealthPartners, 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. The following categories of reliable evidence will be considered, 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 U.S. 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 the American Hospital Formulary Service 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.

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

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

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

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

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

Mental Health Professional. This is a psychiatrist, psychologist, or mental health therapist licensed for independent practice, lawfully performing a mental or chemical health service in accordance with governmental licensing privileges and limitations, who renders mental or chemical health services to Covered Persons as covered under the Plan. 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 rendered by a hospital's outpatient department, or a licensed surgical center and other ambulatory facility (other than in a physician's office).

Period of Confinement. This is (1) one continuous hospitalization, or (2) a series of hospitalizations or skilled nursing facility stays, or periods of time when the Covered Person 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 Covered Persons as covered under the Plan.

Prescription Drug. This is any medical substance for the prevention, diagnosis or treatment of injury, disease or illness approved and/or regulated by the U.S. 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.

Pre-service Claim. This is any claim for a benefit under a group health plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. The only claims under this Plan that meet this definition are those claims that require pre-certification by CareCheck[®].

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

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

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 the Plan, to render inpatient post-acute hospital and rehabilitative care and services to Covered Persons, whose condition requires skilled nursing facility care. It does not include facilities which primarily provide treatment of mental or chemical health.

Subscriber. This is the eligible employee enrolled in the Plan.

Virtuwell. Virtuwell is an online service that you use to receive a diagnosis and treatment for certain routine conditions, such as a cold and flu, ear pain and sinus infections. You may access the virtuwell website at www.virtuwell.com.

Waiting Period. This is the period of time that an individual must wait before being eligible for coverage under the Plan.

III. DESCRIPTION OF COVERED SERVICES

The Plan covers 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 necessary or dentally necessary.

Coverage is subject to the exclusions, limitations, and other conditions of this SPD.

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 logging onto your “myHealthPartners” account at www.healthpartners.com or by calling Member Services.

A. ACUPUNCTURE

The Plan covers acupuncture services when medically necessary.

Covered services and supplies 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 logging onto your “myHealthPartners” account at www.healthpartners.com or by calling Member Services.

B. AMBULANCE AND MEDICAL TRANSPORTATION

The Plan covers certain ambulance and medical transportation for medical emergencies and as shown below.

For Network 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.

C. BEHAVIORAL HEALTH SERVICES

1. Mental Health Services

The Plan covers 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 Covered Person's life.

The Plan also provides 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. The Plan Manager 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. The Plan will cover the evaluation upon which the court order was based if it was provided by a network provider. The Plan also provides 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.** The Plan covers medically necessary 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 covered by the Plan 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 HealthPartners.

- b. **Inpatient Services.** The Plan covers medically necessary 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.

The Plan covers 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 HealthPartners.

The Plan also covers medically necessary psychiatric residential treatment for emotionally handicapped children as diagnosed by a physician. This care must be authorized by HealthPartners 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 SPD. 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

The Plan covers 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 day treatment and intensive outpatient services.** The Plan covers medically necessary outpatient professional services for 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 covered by the Plan for a diagnosed chemical dependency condition include the following:

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

- b. **Inpatient Services.** The Plan covers medically necessary inpatient services in a hospital or primary residential treatment in a licensed chemical health treatment center. Primary residential treatment is an intensive residential treatment program of limited duration, typically 30 days or less.

The Plan covers services provided in a hospital that is licensed by the local state and accredited by Medicare.

Detoxification Services. The Plan covers 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 logging onto your “myHealthPartners” account at www.healthpartners.com or by calling Member Services.

D. CHIROPRACTIC SERVICES

The Plan covers chiropractic services for rehabilitative care, rendered to diagnose and treat acute neuromuscular-skeletal conditions.

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

E. DENTAL SERVICES

- 1. Accidental Dental Services.** The Plan covers dentally necessary services 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.
- 2. Medical Referral Dental Services.**
 - a. Medically Necessary Outpatient Dental Services.** The Plan covers certain 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.** The Plan covers certain medically necessary hospitalization for dental care. This is limited to charges incurred by a Covered Person who: (1) is a child under age five; (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 five 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 four appointments, are required. The requirement of a hospital setting must be due to a Covered Person's underlying medical condition. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist professional fees are not covered. The following are examples, though not all-inclusive, of medical conditions which may require hospitalization for dental services: severe asthma, severe airway obstruction or hemophilia. Hospitalization required due to the behavior of the Covered Person or due to the extent of the dental procedure is not covered.
 - c. Medical Complications of Dental Care.** The Plan covers certain medical complications of dental care. Treatment must be medically necessary care and related to significant medical complications of non-covered dental care, including complications of the head, neck, or substructures.
- 3. Oral Surgery.** The Plan covers certain 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. **Orthognathic Surgery Benefit.** The Plan covers orthognathic surgery for the treatment of severe dysmorphia where a functional occlusion cannot be achieved through non-surgical treatment alone and where a demonstrable functional impairment exists. Functional impairments include but are not limited to significant impairment in chewing, breathing or swallowing. Associated dental or orthodontic services (pre or post operatively including surgical rapid palatal expansion) are not covered as a part of this benefit.
5. **Treatment of Cleft Lip and Cleft Palate.** The Plan covers certain 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 up to age 26 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 necessary for the treatment of cleft lip or cleft palate are not covered. If a dependent child covered under the Plan 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.
6. **Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD).** The Plan covers surgical and non-surgical treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD), when such care is medically necessary. Dental services which are not required to directly treat TMD or CMD are not covered.

F. DIAGNOSTIC IMAGING SERVICES

The Plan covers diagnostic imaging, when ordered by a provider and provided in a clinic or outpatient hospital facility.

For Network Benefits, non-emergency, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) must be provided at a designated facility.

G. DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

The Plan covers certain equipment and services, as described below.

1. Subject to the limitations below, the Plan covers durable medical equipment (including insulin pumps and insulin pump supplies, glucose monitors/meters and their supplies when purchased from a durable medical equipment vendor) and orthotic benefits, including certain disposable supplies. This benefit does not cover diabetic supplies including, but not limited to, needles, lancets and test strips purchased at a pharmacy or Durable Medical Equipment (DME) vendor.

The Plan covers special dietary treatment for Phenylketonuria (PKU) and oral amino acid based elemental formula if it meets HealthPartners medical coverage criteria.

External hearing aids (including osseointegrated or bone anchored) for Covered Persons 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.

The Plan covers foot orthotics (sometimes referred to as inserts) when custom molded (formed or molded to patient model). Covered for treatment of the affected area only.

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 Covered Persons to conduct standard activities of daily living.
 - c. The Plan reserves the right to determine if an item will be approved for rental vs. purchase.
 - d. Compression support stockings are limited to 8 pairs per calendar year.

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: (1) damaged or destroyed by misuse, abuse or carelessness; (2) lost; or (3) 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 a designated 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), fitting of hearing aids, speech processors, receivers, communication boards, or computer or electronic assisted communication, except as specifically described in this SPD. This exclusion does not apply to cochlear implants, which are covered as described in the medical coverage criteria. These medical policies (medical coverage criteria) are available by logging onto your “myHealthPartners” account at www.healthpartners.com or by calling Member Services.
 - 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, whirlpools 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 carriers.
 - k. Rental equipment while the Covered Person's owned equipment is being repaired, beyond one month rental of medically necessary equipment.
 - l. Other equipment and supplies, including but not limited to assistive devices, that the Plan determines are not eligible for coverage.

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

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. The coverage policy for diabetic supplies includes information on the required models and brands. These medical policies (medical coverage criteria) are available by logging onto your “myHealthPartners” account at www.healthpartners.com or by calling Member Services.

H. EMERGENCY AND URGENTLY NEEDED CARE SERVICES

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

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, 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 will be taken into consideration.

The Plan **must be** notified within two working days of admission to an out-of-network hospital, or as soon as reasonably possible under the circumstances.

The Plan covers services for emergency care and urgently needed care if the services are otherwise eligible for coverage in this SPD.

I. HEALTH EDUCATION

The Plan covers education for preventive services and education for the management of chronic health problems (such as diabetes).

J. HOME HEALTH SERVICES

The Plan covers 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 rendered in the Covered Person's home, if the Covered Person 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.

The Plan covers 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.

The Plan covers palliative care benefits. Palliative care includes symptom management, education and establishing goals for care. The requirement that the Covered Person is homebound will be waived 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 or terminal 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. The Plan will not reimburse family members or residents in the Covered Person'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 the Plan.

K. HOME HOSPICE SERVICES

Applicable Definitions:

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

Continuous Care. This is from two to 12 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 a primary caregiver (i.e., family member or friend) who is responsible for the patient's home care.

1. Home Hospice Program. The Plan covers the services described below for Covered Persons who are terminally ill patients and accepted as home hospice program participants. Covered Persons 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. Covered Persons 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 Covered Person 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 determined by HealthPartners medical director or his or her designee over the course of care. A Covered Person 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 Covered Person'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 Covered Person's home or in a setting which provides day care for pain or symptom management, when medically necessary, will be covered.
 - (2) **Inpatient Services:** The Plan covers medically necessary inpatient services.
 - (3) **Other Services:**
 - (a) Respite care is covered for care in the Covered Person'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 semi-electric hospital beds and other durable medical equipment are covered.
- (c) Medically necessary emergency and non-emergency care are covered.

2. **What Is Not Covered.** The Plan does 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 a covered service under this home hospice services section; or
 - e. any services provided by a member of the patient's family or resident in the Covered Person's home.

L. HOSPITAL AND SKILLED NURSING FACILITY SERVICES

1. Medical or Surgical Hospital Services

- a. **Inpatient Hospital Services.** The Plan covers 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.

The Plan covers 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.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Plan Sponsor.

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

- b. **Outpatient Hospital, Ambulatory Care or Surgical Facility Services.** The Plan covers 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 rendered while an outpatient.

For Network Benefits, non-emergency, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) must be provided at a designated facility.

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.

The Plan covers 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.

M. LABORATORY SERVICES

The Plan covers laboratory tests when ordered by a provider and provided in a clinic or outpatient hospital facility.

N. MASTECTOMY RECONSTRUCTION BENEFIT

The Plan covers 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.

O. OFFICE VISITS FOR ILLNESS OR INJURY

The Plan covers the following when medically necessary: professional medical and surgical services and related supplies, including biofeedback, of physicians and other health care providers, and blood and blood products (unless replaced) and blood derivatives.

The Plan also covers diagnosis and treatment of illness or injury to the eyes. Where contact or eyeglass lenses are prescribed as medically necessary for the post-operative treatment of cataracts or for the treatment of aphakia or keratoconus, the initial evaluation, lenses and fitting are covered under the Plan. Covered Persons must pay for lens replacement beyond the initial pair.

The Plan also provides coverage for the initial physical evaluation of a child if it is ordered by a Minnesota juvenile court.

P. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY

The Plan covers 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 and is part of a prescribed treatment plan and is not billed separately is covered.

Q. PRESCRIPTION DRUG SERVICES

The benefits described in this SPD cover only those prescription drugs and medications which are administered in a physician's office, during an emergency room or urgent care visit, an outpatient hospital visit or an inpatient stay. Please note benefits for all outpatient prescription drugs and other pharmacy items are administered by another vendor. For more information regarding this vendor, please contact your employer.

R. PREVENTIVE SERVICES

The Plan covers the following preventive services:

1. Routine health exams and periodic health assessments. A physician or health care provider will counsel Covered Persons as to how often health assessments are needed based on the age, sex and health status of the Covered Person.
2. Well child care, 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 exams and contact lens fittings.
7. Routine hearing exams.
8. Professional voluntary family planning services.
9. Adult immunizations.
10. Women's preventive health services; including mammograms, screenings for cervical cancer; breast pumps; human papillomavirus (HPV) testing; counseling for sexually transmitted infections and counseling and screening for human immunodeficiency virus (HIV); and FDA approved contraceptive methods from a medical provider, sterilization procedures, education and counseling.

A list of preventive services that must be covered at 100% is published by the federal government. 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 logging onto your "myHealthPartners" account at www.healthpartners.com or by calling Member Services.

S. SPECIFIED OUT-OF-NETWORK SERVICES

The Plan covers the following services, when a Covered Person elects to receive them from an out-of-network provider, at the same level of coverage the Plan provides when a Covered Person elects to receive the services from a network provider:

1. Voluntary family planning of the conception and bearing of children.
2. Testing and treatment of sexually transmitted diseases (other than HIV).
3. Testing for AIDS and other HIV-related conditions.

T. TRANSPLANT SERVICES

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

Allogeneic. This is when the source of cells is 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 then reinfused (transplanted).

Allogeneic Bone Marrow Transplant. This is when the bone marrow is harvested from a 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 the Plan to provide services, supplies or drugs for specified transplants for Covered Persons.

Transplant Services. This is transplantation (including retransplants) of the human organs or tissue listed below, including related post-surgical treatment, follow-up care 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. The Plan covers eligible Transplant Services (as defined above) while you are a Covered Person. 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: (a) primary pulmonary hypertension; (b) Eisenmenger's syndrome; (c) end-stage pulmonary fibrosis; (d) alpha 1 antitrypsin disease; (e) cystic fibrosis; and (f) emphysema.
5. Liver transplants for: (a) biliary atresia in children; (b) primary biliary cirrhosis; (c) post-acute viral infection (including hepatitis A, hepatitis B antigen e negative and hepatitis C) causing acute atrophy or post-necrotic cirrhosis; (d) primary sclerosing cholangitis; (e) alcoholic cirrhosis; and (f) hepatocellular carcinoma.
6. Allogeneic bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for: (a) acute myelogenous leukemia; (b) acute lymphocytic leukemia; (c) chronic myelogenous leukemia; (d) severe combined immunodeficiency disease; (e) Wiskott-Aldrich syndrome; (f) aplastic anemia; (g) sickle cell anemia; (h) non-relapsed or relapsed non-Hodgkin's lymphoma; (i) multiple myeloma; and (j) testicular cancer.
7. Autologous bone marrow transplants or peripheral stem cell support associated with high-dose chemotherapy for: (a) acute leukemias; (b) non-Hodgkin's lymphoma; (c) Hodgkin's disease; (d) Burkitt's lymphoma; (e) neuroblastoma; (f) multiple myeloma; (g) chronic myelogenous leukemia; and (h) 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.

To receive Network 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 SPD.

Medical and hospital expenses of the donor are covered only when the recipient is a Covered Person 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 Covered Persons, and are therefore not eligible for the rights afforded to Covered Persons under this SPD.

The list of eligible Transplant Services and coverage determinations are based on established medical policies which are subject to periodic review and modification by HealthPartners medical director.

U. WEIGHT LOSS SURGERY OR BARIATRIC SURGERY

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 logging onto your “myHealthPartners” account at www.healthpartners.com or by calling Member Services.

IV. SERVICES NOT COVERED

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

1. Treatment, procedures, 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 Covered Person, including cognitive retraining and skills training.
2. For Network Benefits, treatment, procedures or services which are not provided by a network provider.
3. Procedures, technologies, treatments, facilities, equipment, drugs and devices which are considered investigative, or otherwise not clinically accepted medical services. The Plan considers vagus nerve stimulator treatment for the treatment of depression and Quantitative Electroencephalogram treatment for the treatment of behavioral health conditions to be investigative and does not cover these services. The Plan considers the following transplants to be investigative and does 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 SPD. While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered.
4. Rest and respite services and custodial care. This includes all services, medical equipment and drugs provided for such care.
5. Room and board and care provided in halfway houses, extended care facilities, or comparable facilities, and residential treatment services.
6. Foster care, adult foster care and any type of family child care provided or arranged by the local state or county.
7. Services associated with non-covered services, including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies.
8. 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.
9. Cosmetic surgery, cosmetic services and treatments primarily for the improvement of the Covered Person's appearance or self-esteem, including, but not limited to, augmentation procedures, reduction procedures and scar revision. This exclusion does not apply to services for port wine stain removal and reconstructive surgery.
10. Commercial weight loss programs and exercise programs.
11. Dental treatment, procedures or services not listed in this SPD.
12. Vocational rehabilitation and recreational or educational therapy.
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. 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; artificial insemination; surrogate pregnancy and related obstetric/maternity benefits; and sperm, ova or embryo acquisition, retrieval or storage.
15. Services and/or surgery for gender reassignment.
16. Maintenance chiropractic therapy.

17. Keratotomy and keratorefractive surgeries, eyeglasses, contact lenses and hearing aids (implantable and external, including osseointegrated or bone anchored) and their fitting, except as specifically described in this SPD. This exclusion does not apply to cochlear implants, which are covered as described in the medical coverage criteria. Medical coverage criteria are available by logging onto your "myHealthPartners" account at www.healthpartners.com or by calling Member Services.
18. 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 specified in this SPD. This exclusion does not apply to oral amino acid based elemental formula if it meets HealthPartners medical coverage criteria.
19. Charges for sales tax.
20. Services provided by a family member of the Covered Person, or a resident in the Covered Person's home.
21. Religious counseling, marital/relationship counseling and sex therapy.
22. Private duty nursing services.
23. Services that are rendered to a Covered Person, who also has other primary insurance coverage for those services and who does not provide the Plan the necessary information to pursue coordination of benefits, as required under the Plan.
24. The portion of a billed charge for an otherwise covered service by a provider, which is in excess of the usual and customary charges, or which is either a duplicate charge for a service or charges for a duplicate service.
25. Charges for services (a) for which a charge would not have been made in the absence of insurance or medical plan coverage, or (b) which the Covered Person is not legally obligated to pay, and (c) from providers who waive copayment, deductible and coinsurance payments by the Covered Person.
26. Travel and lodging incidental to travel, regardless if it is recommended by a physician and any travel billed by a provider.
27. Health club memberships.
28. Massage therapy for the purpose of a Covered Person's comfort or convenience.
29. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
30. Autopsies.
31. 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 24 months from the date of injury.
32. Nonprescription (over-the-counter) drugs or medications, including, but not limited to, vitamins, supplements, homeopathic remedies, and non-FDA approved drugs.
33. Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders, including ABA, IEIBT, and Lovaas.
34. Charges for elective home births.
35. 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 SPD to seek substance abuse treatment.
36. For Network Benefits, 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.
37. Court ordered treatment, except as described under "Mental Health Services" and "Office Visits for Illness and Injury" or as otherwise required by law.
38. Services provided by naturopathic providers.
39. Oral surgery to remove wisdom teeth.
40. Treatment, procedures, or services or drugs which are provided when you are not covered under this Plan.
41. Drugs for the treatment of growth deficiency.
42. All prescription drugs, medications or pharmacy items other than those administered in a physician's office, during an emergency room or urgent care visit, an outpatient hospital visit or an inpatient stay or unless otherwise specified in this SPD.
43. Charges for transplant services received Out-of-Network or by a non-designated transplant center.
44. Elective abortions, except in situations where the life of the mother would be endangered if the fetus is carried to full term.
45. Medication Therapy Disease Management (MTM) consultations administered by HPAI (MTM may be administered by your pharmacy vendor, see your employer for more information).

V. DISPUTES AND COMPLAINTS

A. DETERMINATION OF COVERAGE

Eligible services are covered only when medically necessary for the proper treatment of a Covered Person. HealthPartners 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 HealthPartners medical or dental directors.

If your claim for medical services was denied based on HealthPartners 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.

B. COMPLAINTS

The Plan has a complaint procedure to resolve complaints and disputes. Complaints should be made in writing or orally. They may concern the provision of care by network providers, administrative actions, or claims related to the Plan, including breach, meaning or termination. The complaint system seeks to resolve a dispute which arose during the time of your coverage, or application for coverage.

Complaints must be made to:

HealthPartners

Member Services Department

8170 33rd Avenue South, P.O. Box 1309

Minneapolis, MN 55440-1309

Telephone: 952-883-5000 Outside the metro area: 800-883-2177 (toll-free)

VI. CONDITIONS

A. RIGHTS OF REIMBURSEMENT AND SUBROGATION

If services are provided or paid for under the Plan to treat an injury or illness: (1) caused by the act or omission of another party; (2) covered by no fault insurance or other auto insurance or employers liability laws; (3) available or required to be furnished by or through national or state governments or their agencies; or (4) sustained on the property of a third party, the Plan Sponsor or its designee has the right to recover the reasonable value of services and payments made. This right shall be by reimbursement and subrogation. The right of reimbursement means you must repay the Plan Sponsor or its designee at the time you make any recovery. Recovery means all amounts received by you from any persons, organizations or insurers by way of settlement, judgment, award or otherwise on account of such injury or illness. The right of subrogation means that the Plan Sponsor or its designee may make claim in your name or the Plan Sponsor's name against any persons, organizations or insurers on account of such injury or illness. Attorneys' fees and expenses incurred by a Covered Person in connection with the recovery of monies from third parties may not be deducted from subrogation/reimbursement amounts, unless agreed to by the Plan Sponsor in its discretion.

In addition, the Plan will have a lien on any amounts payable by a third party or under an insurance policy or program, to the extent covered expenses are paid by the Plan Sponsor's Medical Benefit Plan.

The rights of reimbursement and subrogation apply whether or not the Covered Person has been fully compensated for losses or damages by any recovery of payments, and the Plan Sponsor or its designee will be entitled to immediately collect the present value of subrogation rights from said payments.

If, after recovery of any payments, you receive services or incur expenses on account of such injury or illness, you may be required to pay for such services or expenses. The total of all reimbursement and payments will not exceed your recovery.

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

You agree to cooperate fully in every effort by the Plan Sponsor or its designee to enforce the rights of reimbursement and subrogation. You also agree that you will not do anything to interfere with those rights. You agree to promptly inform the Plan Sponsor in writing of any situation or circumstance which may allow the Plan Sponsor to invoke its rights under this section.

B. COORDINATION OF BENEFITS

You agree, as a Covered Person, to permit the Plan Manager to coordinate payments under any other medical benefit plans as specified below, which cover you or your dependents. You also agree to provide any information or submit any claims to other medical benefit plans necessary for this purpose. If you fail to provide this information, your claim may be delayed or denied. You agree to authorize the Plan Manager's billing to other medical plans, for purposes of coordination of benefits.

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

1. Applicability.

- a. This Coordination of Benefits (COB) provision applies to the Plan when a Subscriber or the Subscriber's Covered Dependent has medical care coverage under more than one plan. "Plan" and "The 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 The Plan are determined before or after those of another plan. The benefits of The Plan:
 - (1) shall not be reduced when, under the order of benefit determination rules, benefits under The Plan are determined 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. "**The Plan**" is the part of the Plan that provides benefits for medical care expenses.
- c. "**Primary Plan/Secondary Plan**" The order of benefit determination rules state whether The Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When The Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When The 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, The 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 medical 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 rendered 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, pre-certification 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 The 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 The Plan and another plan, The 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 The Plan; and
- (2) both those rules and The Plan's rules, in subparagraph b. below, require that The Plan's benefits be determined before those of the other plan.

- b. **Rules.** The order of benefits are determined using the first of the following rules which applies:

- (1) **Nondependent/Dependent.** The benefits of the plan which cover the person as a Covered Person 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 The 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 medical 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 medical care expenses of the child, the plans covering the child 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 a Subscriber who is neither laid off nor retired (or as that Subscriber's dependent) are determined before those of a plan which cover that person as a laid off or retired Subscriber (or as that Subscriber'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 a Covered Person 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", The Plan is a Secondary Plan as to one or more other plans. In that event the benefits of The 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 the Plan's Benefits.** The benefits of The 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 The 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 The Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of The Plan.

5. Right to Receive and Release Needed Information. Certain facts are needed to apply these COB rules. The Plan Manager has the right to decide which facts are needed. Consistent with applicable state and federal law, the Plan Manager 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 The Plan must give any facts the Plan Manager needs to pay the claim.

6. Facility of Payment. A payment made under another plan may include an amount which should have been paid under The Plan. If it does, the Plan Sponsor 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 The Plan. The Plan Sponsor 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 the Plan Sponsor is more than the amount that should have paid under this COB provision, the Plan Manager 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 the 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 Covered Person is legally entitled and for which facilities are reasonably available for military service-connected conditions or disabilities. Subject to the Plan's rights in A. "Rights of Reimbursement and Subrogation" above, medically necessary services will be provided upon request and only expenses incurred for medical treatment otherwise covered by the Plan will be paid if the no-fault insurer, employer, or national or state government or its agencies refuse to pay said expenses. You must cooperate with the Plan Manager's program to bill allowable no-fault and workers' compensation claims to the appropriate insurer(s).

C. MEDICARE AND THE PLAN

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

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

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

The benefits under the Plan are considered secondary to those under Medicare if the Covered Person has actually enrolled in Medicare Part B.

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

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

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

A. CONTINUATION OF GROUP COVERAGE

1. **Qualifying Events.** Coverage under the Plan may be continued by a Subscriber, Covered Dependent spouse and other Covered Dependents, enrolled at the time coverage would otherwise end, or a child born to or placed for adoption with the Subscriber 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 Subscriber, or reduction in hours resulting in a loss of group coverage.
 - b. Death of the Subscriber.
 - c. Divorce or legal separation of the Subscriber.
 - d. Loss of eligibility as a Covered Dependent child.
 - e. Initial enrollment of the Subscriber for Medicare.
 - f. For a retired Subscriber, 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. Continuation coverage 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 Subscriber, Covered Dependent spouse or Covered Dependent child.** If the Subscriber, Covered Dependent spouse or other Covered Dependent is disabled under Title II or XVI of the Social Security Act, at any time during the first 60 days of continuation of coverage, the 18-month maximum continuation period may be extended to 29 months. The disabled person must notify the 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 B. "Disabled Employee" below, which describes your rights for coverage as a disabled employee under Minnesota law.
 - (3) **Bankruptcy.** In the case of bankruptcy of a retired Subscriber's former Employer, the maximum period of continuation coverage is until the death of the retired Subscriber. In the case of the surviving spouse or dependent children of the retired Subscriber, the maximum period of continuation coverage is 36 months after the death of the retired Subscriber.
 - (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 Subscriber.** 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 Subscriber. 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 Plan under which this coverage is offered to Subscribers is terminated.
- (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 B. "Disabled Employee" below, which describes your rights for coverage as a disabled employee under Minnesota law.
- (5) **Termination provisions of this Summary Plan Description.** The person's coverage is subject to termination under section I. of this Summary Plan Description.

3. **Election of Continuation Coverage**

- a. You have 60 days to elect continuation of group coverage. The 60-day period begins on the date your group coverage would otherwise terminate due to a qualifying event or the date on which written notice of your right of continued group coverage is mailed, whichever is later.
- b. If you wish to continue group coverage as shown above, you must apply in writing to your Employer (not the Plan). 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 Subscriber, 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 Covered Dependents must notify the Plan Sponsor within 60 days, when divorce, legal separation, a change in status resulting in a loss of eligibility as a dependent would end coverage or a second qualifying event occurs. The 60-day period begins on the date of the divorce, legal separation, change in dependent status or second qualifying event.

4. **Procedures for Providing Notices Required Under This Continuation of Group Coverage Section**

- a. You must comply with the time limits for providing notices required in paragraph 3 (c) above.
- b. Your notice must be in writing and contain at least the following information:
 - (1) The names of the Subscriber and Covered Dependents;
 - (2) the qualifying event or disability; and
 - (3) the date on which the qualifying event (if any) occurred.

- c. Your notice must be sent to:

Duluth Joint Powers Enterprise Trust
402 City Hall
411 West First Street
Duluth, MN 55802

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

B. DISABLED EMPLOYEE

The Plan Sponsor and the Plan agree not to terminate, suspend or otherwise restrict the participation in, or the receipt of, benefits otherwise payable hereunder, to any Subscriber who becomes totally disabled while employed by the Employer and covered hereunder while the Plan is in force, solely due to absence caused by such total disability. The Plan Sponsor may require the Subscriber to pay all or some part of the payment for coverage in this instance. Such payment shall be made to the Plan Sponsor by that Subscriber.

For the purpose of this section the term "total disability" means (1) the inability of an injured or ill Subscriber to engage in or perform the duties of the Subscriber's regular occupation or employment within the first two years of such disability and (2) after the first two years of such disability, the inability of the Subscriber to engage in any paid employment or work for which the Subscriber may, by education or training, including rehabilitative training, be or reasonably become qualified.

C. REPLACEMENT OF COVERAGE AND CONFINED COVERED PERSONS

When the Plan Sponsor replaces the Plan with that of another medical plan offering similar benefits, coverage will be extended for a Covered Person who is confined in an institution or institutions for medical care or treatment that would otherwise be covered under the Plan. 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 Plan are exhausted.

D. 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.

E. CONVERSION TO NON-GROUP COVERAGE

1. **Eligibility for Conversion Coverage.** After a Covered Person has exhausted benefits under "Continuation of Group Coverage," he or she is 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 Covered Persons 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 Covered Person has exhausted his or her continuation right as described in part A. above.
 - b. within 63 days of the date of termination of a Covered Person's group coverage, if the Covered Person is not eligible for continuation under part A. above.If elected, conversion coverage takes effect on the date group coverage ceases or continuation eligibility terminates. The Covered Person must submit the required non-group enrollment prepayment along with an application to convert.

2. **Exception to the right to Conversion Coverage.** A Covered Person will not be allowed to convert to non-group conversion coverage if either of the following has occurred:
 - a. the Covered Person's group health plan sponsor replaces this Plan with another group health program prior to conversion or continues to offer other group health coverage; or
 - b. the Covered Person's coverage was ended for cause under I.K.

VIII. CLAIMS PROCEDURES

A. PROCEDURES FOR REIMBURSEMENT OF NETWORK SERVICES

When you present your identification card at the time of requesting network services from providers, paperwork and submission of claims relating to services will be handled for you by your provider. You may be asked by your provider to sign a form allowing your provider to submit the claim on your behalf. If you receive an invoice or bill from your provider for services, other than coinsurance, copayments or deductible amounts, simply return the bill or invoice to your provider, noting your enrollment in the Plan. Your provider will then submit the claim under the Plan. Your claim will be processed for payment according to the Employer's coverage guidelines.

B. PROCEDURES FOR REIMBURSEMENT OF SERVICES

1. **Claim Forms.** If claim forms are needed, please contact the Plan Manager at 952-883-5000 or 800-883-2177 (toll-free). You must submit claims to the Plan Manager for out-of-network services on the claim form provided. Claim forms must include written proof which documents the date and type of service, provider name and charges, for which a claim is made.
2. **Proof of Loss.** Claims for services must be submitted to the Plan Manager at the address shown below. You must submit an itemized bill, which documents the date and type of service, provider name and charges, for the services incurred. Claims for services must be submitted within 90 days after the date services were first received for the injury or illness upon which the claim is based. Failure to file a claim within this period of time shall not invalidate nor reduce any claim if it was not reasonably possible to file the claim within that time. However, such claim must be filed as soon as reasonably possible and in no event, except in the absence of your legal capacity, later than 15 months from the date services were first received for the injury or illness upon which the claim is based. If the Plan is discontinued or if HPAI ceases to act as the Plan Manager, the deadline for claim submission is 180 days. The Plan Manager may request that additional information be submitted, as needed, to make a claim determination.

Send itemized bills to: Claims Department
 HealthPartners, Inc.
 P.O. Box 1289
 Minneapolis, MN 55440-1289

3. **Time of Payment of Claims.** Benefits will be paid under the Plan within a reasonable time period.
4. **Payment of Claims.** Payment will be made according to the Plan Sponsor's coverage guidelines. All or any portion of any benefits for out-of-network services provided under the Plan on account of hospital, nursing, medical, or surgical services may, at the Plan Manager's option and, unless you request otherwise in writing not later than the time of filing the claim, be paid directly to the out-of-network provider rendering the services.
5. **Physical Examinations and Autopsy.** In the event the Plan Manager or Plan Sponsor requires information from a physical exam or autopsy to properly resolve a claim dispute, the Plan Manager or Plan Sponsor may request this information from you or your legal representative. Failure to submit the required information may result in denial of your claim.

6. **Clerical Error.** If a clerical error or other mistake occurs, that error does not deprive you of coverage for which you are otherwise eligible nor does it give you coverage under the Plan for which you are not eligible. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverage. Determination of your coverage will be made at the time the claim is reviewed. It is your responsibility to confirm the accuracy of statements made by the Plan Sponsor or the Plan Manager, in accordance with the terms of this SPD and other Plan documents.

C. TIME OF NOTIFICATION TO CLAIMANT OF CLAIMS

The only claims under your Plan that meet the definition of “pre-service”, are those that require pre-certification by CareCheck[®]. For purposes of this claim and appeal process, all other claims, including requests for prior authorization, are considered “post-service” claims.

1. Pre-Service Claims (pre-certification requests).

When a request to CareCheck[®] for pre-certification for a non-urgent service is requested, an initial determination must be made within 15 calendar days. This time period may be extended for an additional 15 calendar days, provided that the Plan Manager determines that such extension is necessary due to matters beyond the control of the Plan. If such extension is necessary, you will be notified prior to the expiration of the initial 15-day period.

When a request to CareCheck[®] for pre-certification for an urgent service is requested, an initial determination must be made within 72 hours, so long as all information reasonably needed to make a decision has been provided. In the event that the claimant has not provided all information necessary to make a decision, the claimant will be notified of such failure within 24 hours. The claimant will then be given 48 hours to provide the requested information. The claimant will be notified of the benefit determination within 48 hours after the earlier of receipt of the complete information or the end of the time granted to the claimant to provide the specified additional information.

2. Post-Service Claims.

An initial determination of a claim for benefits must be made by HealthPartners within 30 days. This time period may be extended for an additional 15 days, provided that the Plan Manager determines that such an extension is necessary due to matters beyond the control of the Plan. If such extension is necessary, you will be notified prior to the expiration of the initial 30-day period.

You will receive written notification of any initial adverse claim determination as provided by applicable law.

D. CLAIM DENIALS AND CLAIM APPEALS PROCESS FOR PRE-SERVICE CLAIMS

If your request to CareCheck[®] for pre-certification is wholly or partially denied, you are entitled to appeal that decision. Your Plan provides for two levels of appeal to the named fiduciary of your Plan or its delegate. You may also have the right to an external review as described below. You must exhaust the first and second levels of the appeal process prior to bringing a civil action. The steps in this appeal process are outlined below.

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

Member Services Department
HealthPartners, Inc.
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

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 claim for benefits.

The Plan Manager will review your appeal and will notify you of its decision in accordance with the following timelines:

- If the claim being appealed is for urgent services, you may request an expedited appeal either orally or in writing. Within 72 hours of such request, a decision on your appeal will be made.
- If the claim being appealed is for non-urgent services, a decision on your appeal will be made within 15 days.

The time periods may be extended if you agree.

All notifications described above will comply with applicable law.

2. **Second Level of Appeal.** If after the first level of appeal your request was denied, you or your authorized representative may, within 180 days of the denial, submit a written appeal for review, including any relevant documents, to the Plan Manager and submit issues, comments and additional information as appropriate to:

Member Services Department
HealthPartners, Inc.
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

- If the claim being appealed is for urgent services, you may request an expedited appeal either orally or in writing. Within 72 hours of such request, a decision on your appeal will be made.
- If the claim being appealed is for non-urgent services, a decision on your appeal will be made within 15 days.

The time periods may be extended if you agree.

All notifications described above will comply with applicable law.

E. CLAIM DENIALS AND CLAIM APPEALS PROCESS FOR POST-SERVICE CLAIMS (all claims except requests from CareCheck[®] for pre-certification)

If your post-service claim for benefits under the Plan is wholly or partially denied, you are entitled to appeal that decision. Your Plan provides for two levels of appeal to the named fiduciary of your Plan or its delegate. You may also have the right to an external review described below. You must exhaust the first and second levels of the appeal process prior to bringing a civil action. The steps in this appeal process are outlined below.

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

Member Services Department
HealthPartners, Inc.
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

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 claim for benefits.

The Plan Manager will review your appeal and will notify you of its decision within 30 days.

The time period may be extended if you agree.

All notifications described above will comply with applicable law.

2. **Second Level of Appeal.** If after the first level of appeal, your request was denied, you or your authorized representative may, within 180 days of the denial, submit a written appeal for review, including any relevant documents, to the Plan Manager and submit issues, comments and additional information as appropriate to:

Member Services Department
HealthPartners, Inc.
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

The Plan Manager will review your appeal and will notify you of its decision within 30 days.

The time periods may be extended if you agree.

All notifications described above will comply with applicable law.

- F. EXTERNAL REVIEW PROCEDURES.** You or your authorized representative must request an external review within four months of the adverse decision. If your claim is denied because of an adverse benefit determination, you have the right to request an external review, as described below.

An adverse benefit determination is a denial, reduction, or termination of, or failure to provide or make payment for a benefit for any of the following reasons:

- Failure to provide or make payment for a benefit based on a determination that the person is not eligible to participate in the Plan.
- Failure to provide or make payment for a benefit based on a utilization review.
- Failure to provide or make payment for a benefit based on a determination that the benefit is experimental or investigational.

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

- If you have an adverse benefit determination as defined above, you have the right to request external review.
- To initiate the external review process, you may submit a written request for an external review to the Plan Manager. A fee may be required.
- Upon receipt of the request for external review, the Independent Review Organization must provide immediate notice of the review to the complainant and to the Plan Manager. Within 10 business days, the Covered Person and the Plan Manager must provide the reviewer with any information they wish to be considered. The Covered Person (who may be assisted or represented by a person of their choice) and the Plan Manager 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.
- 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 Covered Person and to the Plan Manager.