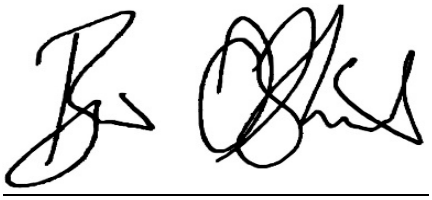
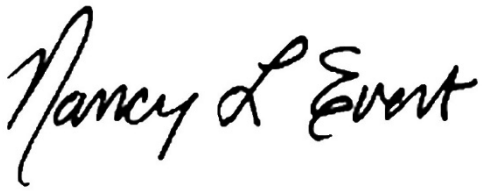
HealthPartners Robin-Select Individual Policy

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



Brian O'Shields, President



Nancy L. Evert, Secretary

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE ENROLLMENT FORM FOR YOUR INSURANCE

Omissions or misstatements in the enrollment form could cause an otherwise valid claim to be denied. Carefully check the enrollment form and write to the insurer within 10 days if any information shown on the form is not correct and complete. The insurance coverage was issued on the basis that the answers to all questions and any other material information shown on the enrollment form are correct and complete.

For Covered Services delivered by participating Network Providers or Out-of-Network Providers that have a contract with us, this is the Provider contracted rate for a given service, procedure or item.

Covered Services delivered by Out-of-Network Providers that do not have a contract with us, this is the usual and customary charge.

The usual and customary charge is the maximum amount allowed that we consider in the calculation of the payment of Charges incurred for certain Covered Services. You may be liable for any Charges above the usual and customary charge, and they do not apply to the Deductible or Out-of-Pocket Limit.

The usual and customary charge is determined using one of the following options in the following order, depending on availability: 1) a percentage of the Medicare fee schedule; 2) a comparable schedule if the service is not on the Medicare fee schedule; or 3) a commercially reasonable rate for such service.

A Charge is incurred for covered Outpatient surgical and non-surgical services and for Inpatient professional and Physician fees on the date the service or item is provided. A Charge is incurred for covered Inpatient Facility fees on the date of Admission to a Hospital and will be covered at the benefit in place on the date of Admission for the duration of your Hospital stay.

To be covered, a Charge must be incurred on or after the Insured's effective date and on or before the termination date of coverage.

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

This Policy is guaranteed renewable except as otherwise provided herein.

Please save for future reference

MGC-200.7-WI-IND
(RS-OMK- 24)

NOTICE: LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED

You should be aware that when you elect to utilize the services of a non-participating Provider for a covered service, benefit payments to such non-participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing Charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the Policy. YOU RISK PAYING MORE THAN THE COINSURANCE, DEDUCTIBLE AND COPAYMENT AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating Providers may bill Enrollees for any amount up to the billed Charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payment for Covered Services with no additional billing to the Enrollee other than copayment, coinsurance and deductible amounts. You may obtain further information about the participating status of professional Providers and information on out-of-pocket expenses by calling 952-967-7540 or 866-232-1166 number on your identification card or visiting HealthPartners' website at healthpartners.com.

Statement of Nondiscrimination for Health Plan Members

Our Responsibilities:
We follow Federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex. We do not exclude people or treat them differently because of their race, color, national origin, age, disability or sex, including gender identity and sexual orientation.

- We help people with disabilities to communicate with us. This help is free. It includes:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio and accessible electronic formats
- We provide services for people who do not speak English or who are not comfortable speaking English. These services are free. They include:
  - Qualified interpreters
  - Information written in other languages

For Language or Communication Help:
Call 1-800-883-2177 if you need language or other communication help. (TTY: 711)

If you have questions about our non-discrimination policy:
Contact the Civil Rights Coordinator at 1-844-363-8732 or integrityandcompliance@healthpartners.com.

To File a Grievance:
If you believe that we have not provided these services or have discriminated against you because of your race, color, national origin, age, disability or sex, you can file a grievance by contacting the Civil Rights Coordinator at 1-844-363-8732, integrityandcompliance@healthpartners.com or Civil Rights Coordinator, Office of Integrity and Compliance, MS 21103K, 8170 33rd Ave. S., Bloomington, MN 55425.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services Room 509F, HHH Building
200 Independence Avenue SW, Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Español *(Spanish)* ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-883-2177. (TTY: 711)	ຄ່ນ ລ໊າວ *(Laotian)* ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-883-2177. (TTY: 711)
Hmoob *(Hmong)* LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-883-2177. (TTY: 711)	Deutsch *(German)* ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-883-2177. (TTY: 711)
Tiếng Việt *(Vietnamese)* CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-883-2177. (TTY: 711)	ر،۱۱ ةيب *(Arabic)* تنبيه :إذا كنت تتحدث العربية ، فإن خدمات المساعدة اللغوية مجانية لك. اتصل بـ :711 (1-800-883-2177.
中文 *(Chinese)* 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-883-2177. (TTY: 711)	Français *(French)* 0 ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-883-2177. (ATS: 711)
Русский *(Russian)* ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-883-2177. (телетайп: 711)	한국어 *(Korean)* 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-883-2177. (TTY: 711) 번으로 전화해 주십시오.
Af Soomaali *(Somali)* OGAYSIIS: Haddii aad ku hadasho afka soomaaliga, Waxaa kuu diyaar ah caawimaad xagga luqadda ah oo bilaash ah. Fadlan soo wac 1-800-883-2177. (TTY: 711)	Tagalog *(Tagalog)* PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-883-2177. (TTY: 711)

21849 (3/2022)

Oromiffa *(Cushite [Oromo])* XIYYEEFFANNAA: Afaan dubbattu Oromiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-883-2177. (TTY: 711)	Italiano *(Italian)* ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-883-2177. (TTY: 711)
አማርኛ *(Amharic)* ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-883-2177. (መስማት ለተሳናቸው: 711)	ภาษาไทย *(Thai)* เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-883-2177. (TTY: 711)
unD *(Karen)* သတိပြုရန် - သင်အူရဒူစကားပြောဆိုပါကဘာသာစကားအကူအညီဝန်ဆောင်မှုများသည်အခမဲ့ဖြစ်သည်။ 1-800-883-2177. (TTY: 711)	ελληνικά *(Greek)* ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-883-2177. (TTY: 711)
ខ្មែរ *(Mon-Khmer, Cambodian)* ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-883-2177. (TTY: 711)	Diné Bizaad *(Navajo)* Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-883-2177. (TTY: 711)
Deitsch *(Pennsylvanian Dutch)* Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-883-2177. (TTY: 711)	Ikirundi *(Bantu – Kirundi)* ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-883-2177. (TTY: 711)
Polski *(Polish)* UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-883-2177. (TTY: 711)	Kiswahili *(Swahili)* KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-883-2177. (TTY: 711)
हिंदी *(Hindi)* ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-883-2177. (TTY: 711)	日本語 *(Japanese)* 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-883-2177 (TTY: 711) まで、お電話にてご連絡ください。
Shqip *(Albanian)* KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-883-2177. (TTY: 711)	नेपाली *(Nepali)* ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-883-2177 (टिटिवाइ: 711)
Srpsko-hrvatski *(Serbo-Croatian)* OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-883-2177. (TTY: 711)	Norsk *(Norwegian)* MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-883-2177. (TTY: 711)
ગુજરાતી *(Gujarati)* સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-883-2177. (TTY: 711)	Adamawa *(Fulfulde, Sudanic)* MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-883-2177. (TTY: 711)
اردو *(Urdu)* ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-883-2177 (رقم هاتف الصم والبكم:711 (TTY:).	Українська *(Ukrainian)* УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-883-2177. (телетайп: 711)

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MISSION

To improve health and well-being in partnership with our Members, patients and community.

ABOUT HEALTHPARTNERS INSURANCE COMPANY AND HEALTHPARTNERS

HealthPartners Insurance Company. HealthPartners Insurance Company is the insurance company underwriting the benefits described in this Policy. HealthPartners Insurance Company is a part of the HealthPartners family of related organizations. HealthPartners Robin plans are underwritten and administered by HealthPartners Insurance Company. When used in this Policy, "we", "us" or "our" has the same meaning as HealthPartners Insurance Company.

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

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

IMPORTANT ENROLLEE INFORMATION

- You have the right to a grace period of 10 days for each premium payment due, when falling due after the first premium payment, during which period the Policy shall continue in force
- Insureds on Medicare have the right to voluntarily disenroll from HealthPartners Insurance Company and the right not to be requested or encouraged to disenroll, except in circumstances specified in federal law
- Insureds on Medicare have the right to a clear description of nursing home and home care benefits covered by HealthPartners Insurance Company
- Certain services or medical or dental supplies are not covered. Read this Policy for a detailed explanation of all exclusions.
- Your Spouse and any Eligible Dependents may purchase their own Policy under certain circumstances
- Your coverage may be cancelled by you or us only under certain conditions. Read this Policy for the reasons for cancellation of coverage.

TERMS AND CONDITIONS OF USE OF THIS POLICY

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

INTRODUCTION TO THE INDIVIDUAL POLICY

INDIVIDUAL POLICY

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

The use of any gender-specific terms refer to sex assigned at birth.

Certain capitalized words have special meanings. We define these words in "Definitions" or within applicable sections. Additional capitalized terms are defined in the Benefits Chart.

GUARANTEED RENEWAL

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

IDENTIFICATION CARD

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

ASSIGNMENT OF BENEFITS

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

PREMIUM PAYMENTS

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

BENEFITS

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

This Policy also provides HealthPartners Out-of-Network Benefits **(Out-of-Network Benefits)** underwritten by HealthPartners Insurance Company, for medical and dental services delivered by Out-of-Network Providers. This Policy describes your Out-of-Network Benefits and how to obtain Covered Services.

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

HealthPartners wants you to get the most out of your health plan and help you live healthier. From time to time, HealthPartners may provide access to additional benefits, healthy discounts and rewards to encourage engagement with health plan benefits. To learn more about programs that may be available, log on to your "myHealthPartners" account at healthpartners.com.

BENEFITS CHART

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

CHANGES IN BENEFITS

We are permitted to change benefits under this Policy to maintain compliance with federal and state law. This includes, but is not limited to, benefit changes required to maintain a certain actuarial value or metal level. We may also change your deductible, copayment and/or coinsurance and out-of-pocket limit values on an annual basis to reflect cost of living increases. No change in this Policy shall be valid until approved by an executive officer of HealthPartners Insurance Company and unless such approval be endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

ENTIRE CONTRACT

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

- This Policy
- The Benefits Chart, and any amendments
- Your enrollment form

AMENDMENTS TO THIS POLICY

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

CONFLICT WITH EXISTING LAW

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

HOW TO USE THE NETWORK

This provision contains information you need to know in order to obtain Network Benefits.

This Policy provides coverage for services provided by our Network of participating Providers and Facilities.

Network Provider. This is any one of the participating licensed Physicians, Dentists, mental health and substance use disorder or other Health Care Providers, Facilities and pharmacies listed in your Network directory, which has entered into an agreement with us to provide Health Care Services to you.

Network Providers are available to view free of charge by logging on to your "*my*HealthPartners" account at healthpartners.com. If you need assistance locating a Physician or other Health Care Providers in your Network, please call Member Services.

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

Out-of-Network Providers. These are licensed Physicians, Dentists, mental health and substance use disorder or other Health Care Providers, Facilities and pharmacies not participating as Network Providers.

ABOUT THE HEALTHPARTNERS NETWORK

To obtain Network Benefits for Covered Services, you must select and receive services from Network Providers. There are limited exceptions as described in this Policy.

HealthPartners Network. These are the Health Care Providers, Facilities and pharmacies contracted to provide services for your plan. They are described in the Network directory.

Designated Physician, Provider or Facility. This is a current list of Network physicians, Providers or Facilities which are authorized to provide certain Covered Services as described in this Policy. Call Member Services for a current list.

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

- Contracted convenience clinics are designated on our web site when you log on to your "myHealthPartners" account at healthpartners.com. You must use a designated convenience clinic to obtain the convenience clinic benefit detailed in your Benefits Chart.
- Durable medical equipment and supplies must be obtained from or repaired by approved vendors
- For Specialty Drugs that are administered in a clinic or an outpatient hospital, your Physician and Facility will obtain the Specialty Drugs from a designated vendor. For Specialty Drugs that are self-administered, you must obtain the Specialty Drugs from a designated vendor to be covered as Network Benefits. Coverage is described in the Benefits Chart.

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

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

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

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

Continuity of Care

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

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

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

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

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

Prior Authorization for Services

There is no referral requirement for services delivered by Providers within your Network. Your Physician may be required to obtain prior authorization for certain services. Your Physician will coordinate the authorization process for any services which must first be authorized. You may call Member Services, or log on to your "*my*HealthPartners" account at healthpartners.com for a list of which services require prior authorization.

Our medical or dental directors, or their designees, make coverage determinations of medical and dental necessity and make final authorization for certain Covered Services. Coverage determinations are based on established Medical and Dental Policies (Coverage Criteria Policies), which are subject to periodic review and modification by the medical or dental directors.

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

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

If the determination is made to approve the service, we will notify your Health Care Provider by telephone, and may send written verification.

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

If you want to request an expedited review, or have received a denial of an authorization and want to appeal that decision, you have a right to do so. If your complaint is not resolved to your satisfaction in the internal complaint and appeal process, you may request an external review under certain circumstances. Refer to information regarding Complaint and Grievance Procedure in the section of this Policy titled, "Disputes and Complaints" for a description of how to proceed.

PREDETERMINATION OF PEDIATRIC DENTAL BENEFITS

If a course of treatment is expected to involve Charges for dental services of $300 or more, it is recommended that a description of the procedures to be performed, an estimate of the Dentist's Charges and an appropriate x-ray pertaining to the treatment, be filed by the Dentist with us in writing, prior to the course of treatment.

A "course of treatment" means a planned program of one or more services or supplies, whether rendered by one or more Dentists, for treatment of a dental condition, diagnosed by the attending Dentist as a result of an oral examination. The course of treatment commences on the date a Dentist first renders a service to correct, or treat, such diagnosed dental condition.

When a predetermination for a service is requested from us, an initial determination must be made within 10 business days, so long as all information reasonably needed to make the decision has been provided.

When a predetermination for an urgent service is requested from us, 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 our receipt of the complete information or the end of the time granted to the claimant to provide the specified additional information.

If the predetermination is made to approve the service, we will notify your dental care Provider by telephone, and may send written verification.

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

If you want to request an expedited review, or have received a denial of a predetermination and want to appeal that decision, you have a right to do so. If your Complaint is not resolved to your satisfaction in the internal Complaint and appeal process, you may request an external review under certain circumstances. Refer to the "Disputes and Complaints" section for a description of how to proceed.

Call Member Services for more information on predetermination of benefits.

We will notify the Dentist of the predetermination, based on the course of treatment. In determining the amount we pay, consideration is given to alternate procedures, services, supplies, or courses of treatment, that may be performed for such dental condition. The amount we pay as authorized dental Charges is the appropriate amount determined in accordance with the terms of the Policy.

If a description of the procedures to be performed, and an estimate of the Dentist's Charges, are not submitted in advance, we reserve the right to make a determination of benefits payable, taking into account alternate procedures, services, supplies or courses of treatment, based on accepted standards of dental practice.

Predetermination for services to be performed is limited to services performed within 90 days from the date such course of treatment was approved by us. Additional services required after 90 days may be submitted in writing, as a new course of treatment, and approved on the same basis as the prior plan.

ACCESS TO RECORDS AND CONFIDENTIALITY

We comply with the state and federal laws governing the confidentiality and use of protected health information and medical or dental records. When your Provider releases health information to us according to state law, we can use your protected health information when necessary, for certain health care operations, including, but not limited to: claims processing, including claims we make for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, case management, care coordination and utilization management, disease management, the evaluation of potential or actual claims against us, auditing and legal services, and other health care operations and use without further authorization if permitted or required by another law.

DEFINITIONS

Authorized Representative. This is anyone acting on your behalf in connection with an initial claim or to issue a Complaint or Grievance.

You may designate an authorized representative by sending an appropriately-worded authorization permitting us to disclose your personal health information to your authorized representative. To designate an authorized representative, you must complete and sign our "Appointment of Authorized Representative" form and return it to us. You should specify on the form the extent of the authorized representative's authority. We will provide you with an authorization form to complete, upon request. This form is also available by logging on to your "*my*HealthPartners" account at healthpartners.com. The purpose of the authorization is to ensure that we have your permission to disclose your personal health information to a third party. Unless otherwise permitted by applicable law, if a third party issues a Complaint or Grievance and we do not have such authorization from you, we will investigate the issue and respond to you directly with the outcome.

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

Dentist. This is a professionally degreed doctor of dental surgery or dental medicine who lawfully performs a dental service in strict accordance with governmental licensing privileges and limitations.

Eligible Dependents. These are the persons shown below. Under this Policy, a person who is considered an Enrollee is not qualified as an eligible dependent. A person who is no longer an eligible dependent (as defined below) on an Enrollee's Policy may convert to their own Policy.

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

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

   The age 26 limit does not apply to a dependent child who was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces, prior to the age of 27, while the child was attending on a full-time basis an institution of higher education. For a dependent child who meets this requirement, coverage will continue for as long as the child is enrolled as a full-time student. A child who is not able to maintain full time student status due to a Medically Necessary leave of absence continues to be an eligible dependent provided the Enrollee sends documentation from the student's treating Physician that certifies the medical necessity of the leave. Coverage for a student who is on a Medically Necessary leave of absence will continue until the earlier of one year from the date that the leave occurs or coverage under this Policy otherwise terminates.
3. **Qualified Grandchild.** This is an unmarried child of a covered Child who is younger than age 18. The Child must be either under 18 years of age, or a Disabled Child, as described below.
4. **Disabled Child.** This is an Enrollee's Child or Qualified Grandchild as defined above, who is (a) incapable of self-sustaining employment by reason of intellectual disability, mental illness or disorder, or physical disability; and (b) chiefly dependent on the Enrollee for support and maintenance. The disability must have come into existence prior to attainment of the limiting age described above. The Enrollee must give us a written request for coverage of a disabled child. The request must include written proof of disability and must be approved by us, in writing. We must receive the request within 31 days of the date an already enrolled dependent becomes eligible for coverage under this definition. We reserve the right to periodically review disability, provided that after the first two years, we will not review the disability more frequently than once every 12 months.

Enrollee. This is a person who is eligible and accepted by us as an Insured per a signed enrollment form and is responsible for payment of premium.

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

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

Insured. This is the Enrollee covered for benefits under this Policy, and all of their eligible and enrolled dependents. When used in this Policy, "you" or "your" has the same meaning.

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

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

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

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

DISPUTES AND COMPLAINTS

DETERMINATION OF COVERAGE

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

COMPLAINTS

1. **In General:** We have a complaint procedure to resolve concerns you may have about benefits, administrative processes, or services from us or from our contracted Providers. Most concerns can be resolved quickly and informally through the complaint process. To start, you may call Member Services. This complaint process is available to Enrollees, applicants, former Enrollees, or any authorized representative acting on behalf of an Enrollee, applicant or former Enrollee seeking to resolve a concern which arose during the Enrollee's membership or enrollment for membership.

2. **Definitions**

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

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

   In addition, an adverse determination includes a 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.

   Complaint. This is an expression of dissatisfaction by you or your authorized representative pertaining to services or benefits provided by us or our contracted Providers during your enrollment or application for enrollment under this Policy. Many complaints or questions can be resolved informally by calling Member Services.

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

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

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

3. **Complaint and Grievance Procedure**

   a. **Complaint Process**

   If you have a concern and would like our assistance, you may call Member Services at 866-232-1166 to issue a complaint. Member Services will investigate the complaint and notify you or your authorized representative of the outcome of our review. We will make every effort to resolve the complaint.

   If you are dissatisfied with our resolution, you may pursue the plan's grievance process. In addition, you may alternately skip this complaint process and proceed directly to the grievance process.

   If your complaint involves a claim for medical services that was denied based on our clinical coverage criteria, your Provider can discuss the decision with a clinician who reviewed the request for coverage. Your Provider should refer to the denial notice for information or call Member Services for assistance.

   b. **Grievance Process**

   You or your authorized representative may seek further review of a complaint not resolved through the complaint process described above. The steps in this grievance process are outlined below.

   (1) **Standard Grievance.** You or your authorized representative must file your written request for review within three years of the adverse decision. Send your written request, including comments, documents, records and other information relating to the grievance, the reasons you believe you are entitled to benefits, and any other supporting information to:

   HealthPartners Insurance Company
   Member Rights & Benefits
   8170 33rd Avenue South
   P.O. Box 1309
   Minneapolis, MN 55440-1309
   Fax: 952-883-9646

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

   Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your grievance.

   If the decision is to deny your request, you or your authorized representative have the right to appear in person before, or by teleconference with, the grievance committee to present any verbal testimony, written comments, records, or documents pertinent to the grievance. We will send you written notification of the date, time and place of the grievance panel meeting at least seven days prior to the meeting date.

   We will review your grievance and notify you in writing of our grievance decision within 30 calendar days of our receipt of your request.

   (2) **Expedited Grievance.** If your grievance concerns urgently-needed services, and the review timeframes specified above could result in adverse health effects, the procedure specified in paragraph (1) above does not apply. For urgently-needed services, you and your Health Care Provider may request an expedited grievance either verbally, by calling Member Services, or in writing. We will review your request as expeditiously as possible, taking into account any medical exigencies. We will provide notification of the outcome of our review within 72 hours. An urgent internal and external review may occur at the same time.

4. **Independent Review Procedures**

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

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

        HealthPartners Insurance Company
        Member Rights & Benefits
        P.O. Box 1309
        Minneapolis, MN 55440-1309
        Fax: 952-883-9646

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

      - Upon receipt of the request for independent review, the Independent Review Organization ("IRO") must provide immediate notice of the review to the complainant and to us. Within 10 business days, the Enrollee and HealthPartners Insurance Company must provide the reviewer with any information they want to be considered. The Enrollee or their authorized representative and HealthPartners Insurance Company shall be given an opportunity to present their facts and arguments. Any aspect of the external review involving medical determinations must be performed by a health care professional with expertise in the medical issue being reviewed.

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

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

5. **Office of the Commissioner of Insurance.** You may contact the **OFFICE OF THE COMMISSIONER OF INSURANCE,** a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at http://oci.wi.gov/, or by writing to:

   Office of the Commissioner of Insurance
   Complaints Department
   P.O. Box 7873
   Madison, WI 53707-7873

   or you can call **800-236-8517** outside of Madison or **266-0103** in Madison, and request a complaint form.

CONDITIONS

RIGHTS OF REIMBURSEMENT AND SUBROGATION

If we provide or pay for services to treat an injury or illness caused by the act or omission of another party, we have the right to recover the value of those services and payments made. This right shall be by reimbursement and subrogation. The right of reimbursement means you must repay us at the time you receive a recovery and we will be entitled to immediately collect the reasonable value of our payments from said settlement fund. The right of subrogation means that we may make claim in your name or our name against any persons, organizations or insurers on account of such injury or illness.

The right of reimbursement and subrogation applies to any type of recovery from any third party, including but not limited to recoveries from tortfeasors, underinsured motorist coverage, uninsured motorist coverage, medical payments coverage, any applicable umbrella coverage, other substitute coverage or any other right of recovery, whether based on tort, contract, equity or any other theory of recovery. The right of reimbursement is binding upon you, your legal representative, your heirs, next of kin and any beneficiary, trustee or legal representative of your heirs or next of kin in the event of your death. Any amounts you receive from such a recovery must be held in trust for our benefit to the extent of our subrogation claims.

You agree to cooperate fully in every effort by us to enforce our rights of reimbursement and subrogation. You also agree that you will not do anything to interfere with those rights. You are required by this Policy to promptly inform us in writing of any potential or pending claim for recovery you may have on account of such injury or illness. Our rights under this part may be subject to and limited by Wisconsin Law but are not limited by our right to recovery from another source. Our rights shall not be reduced by attorney's fees or any other costs of collection incurred by you. We may not have a right to recovery if you have not been made whole, after taking into consideration any comparative negligence. If a dispute arises over the question of whether or not you have been made whole, we have the right to a judicial determination of what dollar amount constitutes full recovery.

COORDINATION OF BENEFITS

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

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

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

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

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

MEDICARE AND THIS POLICY

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

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

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

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

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

EFFECTIVE DATE AND ELIGIBILITY

EFFECTIVE DATE

Open Enrollment Period. If you enroll for coverage during the open enrollment period November 1 – December 15, your coverage will be effective on January 1. If you enroll for coverage December 16 – January 15, your coverage will be effective on February 1.

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

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

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

ELIGIBILITY

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

Open Enrollment Period. The open enrollment period begins on November 1 and extends through January 15. The annual open enrollment period and the date you have to enroll yourself and any Eligible Dependents are defined under federal law and may vary.

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

1. You must enroll yourself and any Eligible Dependents within 30 days of any of the following HIPAA qualifying events listed under this item 1:
    - If you or your dependents lose group coverage because of termination of employment (except for gross misconduct) or reduction in hours
    - If you or your dependents lose group coverage because of the death of the Enrollee
    - If you or your dependents lose group coverage because of divorce or legal separation
    - If your dependent loses group coverage because of loss of eligibility as a dependent child
    - If you or your dependents lose group coverage because the group Enrollee's initial enrollment for Medicare
    - For a retired Enrollee, spouse and other dependents, if you lose group coverage because of the bankruptcy filing by a former employer, under Title XI, United States Code, on or after July 1, 1986
2. You must enroll yourself and any Eligible Dependents within 60 days of any of the following ACA qualifying events listed below:
    - If you or any of your Eligible Dependents lose minimum essential coverage (failure to pay premium or a rescission of coverage allowed under federal law do not qualify as a loss of minimum essential coverage). If you or any of your Eligible Dependents lose minimum essential coverage, you may enroll anytime during the period starting 60 days prior to and ending 60 days following your loss of minimum essential coverage.
    - If you have any newly acquired dependents through marriage, birth, adoption, or placement for adoption, or through a child support order or other court order
    - If you are qualified, but experience an error in enrollment
    - If you are enrolled in another Qualified Health Plan and you successfully demonstrate to the Marketplace that your Qualified Health Plan has substantially violated a material provision of its Policy
    - If you are newly eligible or lose eligibility for advance payment of the premium tax credit, or you experience a change in eligibility for cost sharing reductions
    - If you become eligible for a new Qualified Health Plan offered through the Marketplace because of a permanent move and you had minimum essential coverage for one or more days during the 60 days prior to the permanent move

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

Enrollment of Newborn or Newly Adopted Children. Your newborn child, or covered dependent's newborn child, is automatically covered for the first 60 days after birth. Your adopted child or child placed for adoption is covered for the 60 days immediately following the date the child is placed in your home or the date of the final court order granting the adoption. If premium is required to add the child for coverage under this Policy you must notify us and send the required premium within 60 days of the child's birth, adoption or placement for adoption. If premium is not required to add the child under this Policy, you should still notify us as soon as possible, so we can enroll the child in the plan.

If you do not notify us, or do not pay the required premium, within the initial 60 day period following birth, adoption or placement for adoption and you would like to add your child or grandchild for coverage, you may add the child for up to one year from the date of birth or adoption if you pay the required premium; premium payments that are past due may be subject to interest. If you do not add your child or grandchild within one year, that child will be considered a late entrant.

CHANGES IN COVERAGE

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

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

TERMINATION

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

VOLUNTARY TERMINATION

You may terminate this Policy at any time. Coverage for you and your enrolled dependents terminates on the date specified by you in writing, provided that you have given 14 days advance notice of termination. If you do not give 14 days advance notice of termination, coverage under this Policy will terminate 14 days following your request for termination. You cannot retroactively cancel this Policy.

Written notice must be sent to HealthPartners Insurance Company Attn.: Membership Accounting Department, 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

INVOLUNTARY TERMINATION

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

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

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

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

TERMINATION FOR CAUSE

- The premium payment is due on or before the first of each month that coverage is provided. There is a 10-day grace period during which to pay the required premium. Coverage under this Policy will continue in force during the grace period. If no payment is received by us within the 10-day grace period, coverage terminates retroactive to the paid through date.
- In the event of misstatements made by the applicant in the enrollment form for coverage under this Policy, no misstatement, except fraudulent misstatements, shall be used to void this Policy or deny a claim for benefits covered under this Policy for loss incurred or disability commencing after the expiration of the two year period beginning from the issue date of this Policy. No claim for loss incurred commencing after two years from the effective date of the Policy is reduced or denied on the ground that a disease or physical condition not excluded from benefits by name or specific description effective on the date of loss, has existed prior to the effective date of coverage under this Policy.

CLAIMS PROVISIONS

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

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

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

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

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

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

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

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

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