

# *Appendix A*

## Description of Plan Benefits

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*HealthPartners Minnesota Plan  
HealthPartners Open Access*

*Effective January 1, 2018*

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## I. INTRODUCTION TO HEALTHPARTNERS

**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.

### HEALTHPARTNERS MISSION

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

#### A. HEALTHPARTNERS ADMINISTRATORS, INC. (“HPAI”)

HPAI is the Claims Administrator of the Plan, and is a third party administrator (TPA) which is a related organization of HealthPartners, Inc.

#### B. HEALTHPARTNERS, INC. (“HealthPartners”)

HealthPartners is a Minnesota non-profit corporation and managed care organization.

#### C. 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.

#### D. HOW TO USE THE NETWORK

This SPD describes your covered services and how to obtain them. **The Plan provides 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 check on-line by logging onto your “myHealthPartners” account at [www.healthpartners.com](http://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.

**To see what physicians and other health care providers are in your network, log onto your “myHealthPartners” account at [www.healthpartners.com](http://www.healthpartners.com) or create one at [www.healthpartners.com](http://www.healthpartners.com). If you need assistance locating a physician or other health care providers in your network, please contact Member Services.**

**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.**

**Network.** This is the network of participating network providers.

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

**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.

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 Service Department or check on-line by logging onto your “myHealthPartners” account at [www.healthpartners.com](http://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 disabled children; and (3) mental health services provided in the home.

Convenience care scheduled telephone visits must be provided by a designated, network provider.

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](http://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.

Weight loss surgery must be provided by a designated physician.

Multidisciplinary pain management must be provided at designated facilities.

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

For specialty drugs that are self-administered, you must obtain the specialty drugs from a designated vendor to be covered as Network Benefits.

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 will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment was available previously.

# HealthPartners Open Access

## II. SCHEDULE OF PAYMENTS

See Sections IV. and V. of this Description of Plan Benefits 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.

Coverage may also vary depending on whether you are receiving services from a HealthPartners network primary care provider, or from a HealthPartners network specialty care provider.

Most benefits are not covered when you use Out-of-Network Providers. The only exceptions to this requirement are described below in the “Emergency and Urgently Needed Care Services” section. This section describes what benefits are covered at the Network Benefit level regardless of who provides the service.

### DEFINITIONS:

#### Charge:

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

For covered services delivered by out-of-network providers, a contracted rate may apply if such arrangement is available to the Plan Manager.

For the usual and customary charge for covered services delivered by out-of-network providers, the Plan's payment is calculated using one of the following options to be determined at the Plan Manager's discretion: 1) a percentage of the Medicare fee schedule; 2) a comparable schedule if the service is not available on the Medicare fee schedule; or 3) a commercially reasonable rate for such service.

The usual and customary charge is the maximum amount allowed which the Plan considers in the calculation of the payment of charges incurred for certain covered services. 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, inpatient professional fees, and surgical services 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. To be covered, a charge must be incurred on or after the Covered Person's effective date and on or before the termination date.

#### 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 Description of Plan Benefits.

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.

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. 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.

Amounts paid or reimbursed by a third party, including but not limited to: point of service rebates, manufacturer coupons, debit cards or other forms of direct reimbursement to a Covered Person for a product or service, may not apply toward your deductible.

**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 you exceed any visit or day limits.

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

Amounts paid or reimbursed by a third party, including but not limited to: point of service rebates, manufacturer coupons, debit cards or other forms of direct reimbursement to a Covered Person for a product or service, may not apply as an out-of-pocket expense.

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 Description of Plan Benefits.

**Network Benefits**

<b>Individual Calendar Year Deductible</b>	None.
<b>Family Calendar Year Deductible</b>	None.
<b>Individual Calendar Year Out-of-Pocket Limit</b>	\$3,000
<b>Family Calendar Year Out-of-Pocket Limit</b>	\$5,000



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

**Network Benefits**

- A. ACUPUNCTURE** \$30 copayment and 100% thereafter per office visit.
- B. AMBULANCE AND MEDICAL TRANSPORTATION** 80% of the charges incurred.
- C. BEHAVIORAL HEALTH SERVICES**
- Mental Health Services**
- a. Outpatient Services, including day treatment and intensive outpatient services \$15 copayment and 100% thereafter per office visit.  
*For family therapy, only one copayment will be charged, regardless of the number of family members primarily involved in the therapy.*
- Group Therapy \$7.50 copayment and 100% thereafter per office visit.
- b. Inpatient Services, including psychiatric treatment for emotionally disabled children \$250 copayment and 100% thereafter per admission.
- Chemical Health Services**
- a. Outpatient Services, including day treatment, group therapy and intensive outpatient services \$15 copayment and 100% thereafter per office visit.  
*For family therapy, only one copayment will be charged, regardless of the number of family members primarily involved in the therapy.*  
*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.*
- b. Inpatient Services \$250 copayment and 100% thereafter per admission.
- D. CHIROPRACTIC SERVICES** \$30 copayment and 100% thereafter per office visit.
- E. CLINICAL TRIALS** 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.

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

**Network Benefits**

**F. DENTAL SERVICES**

**Accidental Dental Services**

- |   |   |
|---|---|
| a. Accidental Dental Services Within the Network            | 80% of the charges incurred.                          |
| b. Emergency Accidental Dental Services Outside the Network | \$50 deductible and 80% thereafter per calendar year. |

*For all accidental dental services, treatment and/or restoration must be initiated within 12 months of the date of the injury. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration. Services must be provided within 24 months of the date of injury to be covered.*

**Medical Referral Dental Services**

- |   |  |
|---|--|
| a. Medically Necessary Outpatient Dental Services                     | \$30 copayment and 100% thereafter per office visit. |
| b. Medically Necessary Hospitalization and Anesthesia for Dental Care | \$250 copayment and 100% thereafter per admission.   |
| c. Medical Complications of Dental Care                               | \$30 copayment and 100% thereafter per office visit. |

**Oral Surgery**

\$30 copayment and 100% thereafter per office visit.

**Orthognathic Surgery Benefit**

75% of the charges incurred.

**Treatment of Cleft Lip and Cleft Palate of a Dependent Child**

\$30 copayment and 100% thereafter per office visit.

**Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD)**

\$30 copayment and 100% thereafter per office visit.

**G. DIAGNOSTIC IMAGING SERVICES**

*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)*

**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.  |
| b. All other outpatient diagnostic imaging services                          | 100% of the charges incurred. |

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

**Network Benefits**

**H. DURABLE MEDICAL EQUIPMENT, PROSTHETICS ORTHOTICS AND SUPPLIES**

Special dietary treatment for Phenylketonuria

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 hair loss resulting from alopecia areata are limited to one per calendar year. No more than a 93-day supply of diabetic supplies will be covered and dispensed at a time.*

**I. EMERGENCY AND URGENTLY NEEDED CARE SERVICES**

Urgently Needed Care provided at network or out-of-network clinics

\$40 copayment and 100% thereafter per office visit.

Emergency care in a network or out-of-network hospital emergency room, including professional services of a physician

\$100 copayment and 100% thereafter per emergency room visit.

*Emergency room copayment is waived if admitted for the same condition within 24 hours.*

Inpatient emergency care in a network or out-of-network hospital

\$250 copayment and 100% thereafter per admission.

*Out-of-Network professional fees will be paid at the Inpatient Hospital Services Benefit level if the Covered Person is admitted inpatient to a network hospital through the emergency room.*

**J. HEALTH EDUCATION**

Health education for preventive services is covered at the benefit level shown in the Preventive Services section.

**K. HOME HEALTH SERVICES**

**Physical therapy, occupational therapy, speech therapy, respiratory therapy, home health aide services and palliative care**

Primary Care Providers

\$15 copayment and 100% thereafter per visit.

Specialty Care Providers

\$30 copayment and 100% thereafter per visit.

*If more than one home health visit occurs in a day, a separate copayment applies to each visit.*

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

**Network Benefits**

**TPN/IV therapy, skilled nursing services, non-routine prenatal/postnatal services, and phototherapy**

100% of the charges incurred.

*Each 24-hour visit (or shifts of up to 24-hour visits) equals one visit and counts toward the maximum visits for all other services shown below. Any visit that lasts less than 24 hours, regardless of the length of the visit, will count as one visit toward the maximum visits for all other services shown below. All visits must be medically necessary and benefit eligible.*

*If you are eligible to receive palliative care in the home and you are not homebound, there is a maximum of 12 visits per calendar year.*

*For all other services that meet the home health services requirements described in this SPD, there is a maximum of 120 visits per calendar year.*

**Routine postnatal well child visits**

100% of the charges incurred.

*The routine postnatal well child visits do not count toward the visit limit above.*

**L. HOME HOSPICE SERVICES**

100% of the charges incurred.

*Respite care is limited to five days per episode, and respite care and continuous care combined are limited to 30 days.*

**M. HOSPITAL AND SKILLED NURSING FACILITY SERVICES**

**Medical or Surgical Hospital Services**

a. Inpatient Hospital Services

\$250 copayment and 100% thereafter per admission.

*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.*

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)*

\$30 copayment and 100% thereafter per visit.

**Skilled Nursing Facility Care**

\$250 copayment and 100% thereafter per admission.

*Limited to 120 day maximum per period of confinement.*

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

**Network Benefits**

**N. INFERTILITY SERVICES**

80% of the charges incurred.

**O. LABORATORY SERVICES**

*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)*

**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**

100% of the charges incurred.

**P. 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.

**Q. MEDICATION THERAPY DISEASE MANAGEMENT PROGRAM**

100% of the charges incurred.

**R. OFFICE VISITS FOR ILLNESS OR INJURY**

**Office visits**

Primary Care Providers

\$15 copayment and 100% thereafter per office visit.

Specialty Care Providers

\$30 copayment and 100% thereafter per office visit.

**Convenience clinics**

\$10 copayment and 100% thereafter per office visit.

**Scheduled telephone visits**

\$10 copayment and 100% thereafter per visit.

**E-visits**

\$10 copayment and 100% thereafter per visit.

**Injections administered in a Physician's office**

Allergy injections

100% of the charges incurred.

All other injections

100% of the charges incurred.

**S. OUT OF AREA CARE**

Authorized Care Outside the Service Area

80% of the charges incurred.

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

**Network Benefits**

**T. 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 and habilitative therapy**

Primary Care Providers

\$15 copayment and 100% thereafter per office visit.

Specialty Care Providers

\$30 copayment and 100% thereafter per office visit.

**U. PRESCRIPTION DRUG SERVICES**

**Drugs and medications must be obtained at a network pharmacy.**

**Outpatient Drugs (except as specified below)**

Generic formulary drugs are covered at 100% of the charges incurred, subject to a copayment of \$5 for a low cost generic drug or a copayment of \$15 for a high cost generic drug per prescription.

Brand name formulary drugs are covered at 100% of the charges incurred, subject to a \$35 copayment per prescription.

Non-formulary drugs are covered at 100% of the charges incurred, subject to a \$60 copayment per prescription.

Formulary contraceptives are covered at 100% of the charges incurred.

Drugs for breast cancer prevention are covered at 100% of the charges incurred for women at high risk for breast cancer who have not yet been diagnosed with the disease.

*Drugs for the treatment of sexual dysfunction are limited to six doses per month.*

**Tobacco cessation products, as determined by HealthPartners.**

Must be prescribed by a licensed provider.

100% of the charges incurred.

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

**Network Benefits**

**Mail Order Drugs**

You may also get outpatient prescription drugs which can be self-administered through HealthPartners mail order service. Outpatient drugs ordered through this service are covered at the benefit percent shown in Outpatient Drugs above, subject to two copayments for each 93-day supply or portion thereof.

Drugs for the treatment of sexual dysfunction are limited to 18 doses per 93-day supply.

Specialty drugs are not available through the mail order service.

**Drugs for treatment of infertility**

80% of the charges incurred.

*Drugs for the treatment of infertility are subject to a \$3,000 maximum benefit per calendar year and must be obtained from a designated vendor.*

**Diabetic supplies purchased at a pharmacy**

80% of the charges incurred.

**Specialty drugs which are self-administered**

Generic formulary drugs are covered at 100% of the charges incurred, subject to a copayment of \$5 for a low cost generic drug or a copayment of \$15 for a high cost generic drug per prescription.

Brand name formulary drugs are covered at 100% of the charges incurred, subject to a \$35 copayment per prescription.

Non-formulary drugs are covered at 100% of the charges incurred, subject to a \$60 copayment per prescription.

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

**Network Benefits**

Drugs for the treatment of growth deficiency

80% of the charges incurred.

*Specialty drugs are limited to drugs on the specialty drug list, and must be obtained from a designated vendor.*

*Unless otherwise specified above in the Prescription Drug Services section, you may receive up to a 31-day supply per prescription. Certain drugs may require prior authorization as indicated on the formulary. The Plan may require prior authorization for the drug and also the site where the drug will be provided. All drugs are subject to HealthPartners utilization review process and quantity limits. New prescriptions to treat certain chronic conditions are limited to a 31-day supply. In addition, certain drugs may be subject to any quantity limits applied as part of the trial program. The trial drug program applies to new prescriptions for certain drugs which have high toxicity, low tolerance, high costs and/or high potential for waste. Trial drugs are indicated on the formulary and/or the specialty drug list. Your first fill of a trial drug may be limited to less than a month supply. If the drug is well tolerated and effective, you will receive the remainder of your first month supply. Certain non-formulary drugs require prior authorization. A 93-day supply will be covered and dispensed at a time only at pharmacies that participate in the HealthPartners extended day supply program. No more than a 31-day supply of specialty drugs will be covered and dispensed at a time, unless it's a manufacturer supplied drug that cannot be split that supplies the Covered Person with more than a 31-day supply.*

*Drugs on the Excluded Drug List are not covered. The Excluded Drug List includes select drugs within a therapy class that are not eligible for coverage. You can find the Excluded Drug List if you go to [healthpartners.com](http://healthpartners.com), select Pharmacy and select any of the formularies.*

*If you request a brand name drug when there is a generic equivalent, the brand name drug will be covered up to the charge that would apply to the generic drug, minus any required copayment. If a physician requests that a brand name drug be dispensed as written (DAW), the drug will be paid at the non-formulary benefit.*

*If a copayment is required, you must pay one copayment for each 31-day supply or portion thereof, or for each manufacturer's pre-packaged dispensing units, if applicable, except as follows:*

*For insulin, a copayment will apply per vial or box of insulin cartridges.*

*For mail order drugs, see benefit above.*

**V. PREVENTIVE SERVICES**

- |  |   |
|--|---|
| <b>1. Routine health exams and periodic health assessments</b> | 100% of the charges incurred.   |
| <b>2. Child health supervision services</b>                    | 100% of the charges incurred.   |
| <b>3. Routine prenatal care</b>                                | \$15 copayment for the initial visit of pregnancy, then 100% of the charges incurred for any subsequent visits. |
| <b>4. Routine postnatal care</b>                               | 100% of the charges incurred.   |
| <b>5. Routine screening procedures for cancer</b>              | 100% of the charges incurred.   |
| <b>6. Routine eye and hearing exams</b>                        | 100% of the charges incurred.   |
| <b>7. Professional voluntary family planning services</b>      | 100% of the charges incurred.   |
| <b>8. Adult immunizations</b>                                  | 100% of the charges incurred.   |



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

**Network Benefits**

**9. Women’s preventive health services including all FDA approved contraceptive methods as prescribed by a physician (see prescription drug services section for coverage of contraceptive drugs)**

100% of the charges incurred.

**10. Obesity screening and management**

100% of the charges incurred.

**W. 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.

**X. TRANSPLANT SERVICES**

\$250 copayment and 100% thereafter per admission.

**Y. 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.

### III. MORE DEFINITIONS

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

**Biosimilar Drugs.** A prescription drug, approved by the Food and Drug Administration (FDA), that the FDA has determined is biosimilar to and interchangeable with a biological brand name drug. Biosimilar drugs are not considered generic drugs and are not covered under the generic drug benefit.

**Brand Name Drug.** A prescription drug approved by the Food and Drug Administration (FDA), that is manufactured, sold, or licensed for sale under a trademark by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired. A few brand name drugs may be covered at the generic drug benefit level if this is indicated on the formulary.

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

**CareLine<sup>SM</sup> 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 Employee.** This is the eligible employee 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.

**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.

**ERISA.** The Employee Retirement Income Security Act of 1974, as amended.

**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.

**Formulary.** This is a current list, which may be revised from time to time, of formulary prescription drugs, medications, equipment and supplies covered under the Plan as indicated in the Schedule of Payments which are covered at the highest benefit level. Some drugs may require prior authorization to be covered as formulary drugs. The formulary, and information on drugs that require prior authorization, are available by logging onto your “myHealthPartners” account at [www.healthpartners.com](http://www.healthpartners.com) or by calling Member Services.

**Generic Drug.** A prescription drug, approved by the Food and Drug Administration (FDA), that the FDA has determined is comparable to a brand name drug product in dosage form, strength, route of administration, quality, intended use and documented bioequivalence. Generally, generic drugs cost less than brand name drugs. Some brand name drugs may be covered at the generic drug benefit level if this is indicated on the formulary.

**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.

**Late Enrollee.** This is an eligible employee or dependent who enrolls under the Plan other than during:

1. the first period in which the individual is eligible to enroll under the Plan; or
2. the Employer's annual open enrollment period; or
2. a special enrollment period.

**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.

**Non-Formulary Drug.** This is a prescription drug, approved by the Food and Drug Administration (FDA), that is not on the formulary, is medically necessary and is not investigative or otherwise excluded under this Plan.

**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.

**Primary Care Providers.** These are providers in the following categories: Family Practice, General Practice, Internal Medicine, Pediatrics, Adolescent Medicine, Adult Medicine and Geriatrics.

**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.

**Specialty Care Providers.** These are providers who are not in the following categories: Family Practice, General Practice, Internal Medicine, Pediatrics, Adolescent Medicine, Adult Medicine and Geriatrics.

**Specialty Drug List.** This is a current list, which may be revised from time to time, of prescription drugs, medications, equipment and supplies, which are typically bio-pharmaceuticals. The purpose of a specialty drug list is to facilitate enhanced monitoring of complex therapies used to treat specific conditions. The specialty drug list is available by logging onto your "myHealthPartners" account at [www.healthpartners.com](http://www.healthpartners.com) or by calling Member Services.

**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](http://www.virtuwell.com).

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

## IV. 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. Covered prescription drugs are based on requirements established by the HealthPartners Pharmacy and Therapeutics Committee, and are subject to periodic review and modification. These medical policies (medical coverage criteria) and formulary requirements are available by logging onto your “myHealthPartners” account at [www.healthpartners.com](http://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](http://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 medically necessary, non-emergency medical transportation if it meets HealthPartners medical coverage criteria.

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) and applicable prior authorization requirements are available by logging onto your “myHealthPartners” account at [www.healthpartners.com](http://www.healthpartners.com) or by calling Member Services.

### 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 – Fifth Edition (DSM 5) (most recent edition) that lead to significant disruption of function in the Covered Person's life.

- 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;
- (6) Psychotherapy and nursing services provided in the home if authorized by HealthPartners; and
- (7) Treatment for gender dysphoria that meets medical coverage criteria.

- 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 disabled 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 Department of Health and Human Services. 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 Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM 5) (most recent edition).

- 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 Department of Health and Human Services.

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 Department of Health and Human Services.

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](http://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. CLINICAL TRIALS**

The Plan covers certain routine services if you participate in a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition as defined in the Affordable Care Act. The Plan covers routine patient costs for services that would be eligible under this Plan if the service were provided outside a clinical trial.

## **F. DENTAL SERVICES**

### **1. Accidental Dental Services.**

- a. **Accidental Dental Services Within the Network.** 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. The Plan covers restorations, root canals, crowns and replacement of teeth lost that are directly related to the accident in which the Covered Person was involved. The Plan covers initial exams, x-rays, and palliative treatment including extractions, and other oral surgical procedures directly related to the accident. Subsequent treatment must be initiated within 12 months of the date of the injury and must be related to the accident. The Plan does not cover restoration and replacement of teeth that are not “sound and natural” at the time of the accident.

Full mouth rehabilitation to correct occlusion (bite) and malocclusion (misaligned teeth not due to the accident) are not covered.

When an implant-supported dental prosthetic treatment is pursued, the accidental dental benefit will be applied to the prosthetic procedure. Benefits are limited to the amount that would be paid toward the placement of a removable dental prosthetic appliance that could be used in the absence of implant treatment. Care must be provided or pre-authorized by a network dentist.

- b. **Emergency Accidental Dental Services Outside the Network.** The Plan covers emergency accidental dental services provided by an out-of-network dentist to the same extent as eligible services specified above.

### **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 and anesthesia 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; (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 (5) when extensive amounts of restorative care, exceeding four appointments, are required. Coverage is limited to facility and anesthesia charges. Anesthesia is covered in a hospital or a dental office. 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. Except as listed above, 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 skeletal 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.

## G. 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.

## H. DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

The Plan covers equipment and services, as described below.

1. The Plan covers durable medical equipment and services, prosthetics, orthotics and supplies, subject to the limitations below, including certain disposable supplies, enteral feedings, and the following diabetic supplies and equipment: glucose monitors, insulin pumps, syringes, blood and urine test strips and other diabetic supplies as deemed medically appropriate and necessary, for Covered Persons with gestational, Type I or Type II diabetes.

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

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.

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.
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](http://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](http://www.healthpartners.com) or by calling Member Services.

## **I. 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. You may call **CareCheck®** at **952-883-6400** in the Minneapolis/St. Paul metro area at **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.

Out-of-network coverage under this section stops when treatment for the condition no longer meets the definition of emergency care or urgently needed care, or when the Covered Person's condition permits him or her to receive care within the network.

## **J. HEALTH EDUCATION**

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

## **K. HOME HEALTH SERVICES**

The Plan covers skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy and other therapeutic services, non-routine prenatal and postnatal services, routine postnatal well child visits, as described in the medical coverage criteria, 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.

## L. 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 medications for pain and symptom management.
  - (c) Medically necessary semi-electric hospital beds and other durable medical equipment are covered.
  - (d) 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.

## M. 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, including gender reassignment surgery that meets medical coverage criteria.

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.

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

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, including gender reassignment surgery that meets medical coverage criteria.

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 that meets medical coverage criteria.

**N. INFERTILITY SERVICES**

The Plan covers certain professional services, services for the diagnosis and treatment of infertility, medically necessary tests, facility charges and laboratory work related to covered services.

**O. LABORATORY SERVICES**

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

**P. 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 treatment for physical complications during all stages of mastectomy, including lymphedemas.

**Q. MEDICATION THERAPY DISEASE MANAGEMENT PROGRAM**

If you meet criteria for coverage, you may qualify for the Medication Therapy Disease Management Program.

The Program covers consultations with a designated network pharmacist.

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](http://www.healthpartners.com) or by calling Member Services.

## **R. 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.

## **S. OUT OF AREA CARE**

**Authorized Care Outside the Service Area.** These services are for Covered Persons traveling outside of the service area and for enrolled full-time dependent students who are eligible under the definition of full-time student (see medical coverage criteria) and attending a post-secondary institution outside of the service area. The Plan covers services from an out-of-network provider which cannot be delayed if a Covered Person has an illness, injury or condition while outside the service area. This coverage excludes preventive services (such as routine health exams), scheduled inpatient hospital and skilled nursing facility services and elective surgical procedures. This coverage requires prior authorization as described in the section "About The Network", and is subject to all other limitations set forth in this SPD. Medical policies (medical coverage criteria) are available by calling Member Services, or online at [www.healthpartners.com](http://www.healthpartners.com).

## **T. 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.

## **U. PRESCRIPTION DRUG SERVICES**

The Plan covers prescription drugs and medications, which can be self-administered or are administered in a physician's office.

## **V. PREVENTIVE SERVICES**

The Plan covers the following preventive services at 100%, to the extent they are preventive services and are required to be covered by federal law:

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. This includes counseling for tobacco cessation.
2. Child health supervision services, including pediatric preventive services, routine immunizations, developmental assessments and laboratory services appropriate to the age of the child from birth to 72 months, and appropriate immunizations to age 18.
3. Routine prenatal care and exams to include visit-specific screening tests, education and counseling.
4. Routine postnatal care and exams to include health exams, assessments, education and counseling relating to the period immediately after childbirth.

5. Routine screening procedures for cancer.
6. Routine eye and hearing exams.
7. Professional voluntary family planning services.
8. Adult immunizations.
9. Women's preventive health services; including mammograms, screenings for cervical cancer; breast pumps; human papillomavirus (HPV) testing; counseling for sexually transmitted infections; counseling and screening for human immunodeficiency virus (HIV); and FDA approved contraceptive methods, sterilization procedures, education and counseling.
10. Obesity screening and counseling is covered for all ages during a routine preventive care exam. If you are age 18 or older and have a body mass index of 30 or more, intensive obesity management is covered to help you lose weight. Your primary care physician can coordinate the services.

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](http://www.healthpartners.com) or by calling Member Services.

#### W. 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. The provider visit(s) and test(s) necessary to make a diagnosis of infertility.
3. Testing and treatment of sexually transmitted diseases (other than HIV).
4. Testing for AIDS and other HIV-related conditions.

#### X. 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 Transplant 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 all related post-surgical treatment, follow-up care and drugs and multiple transplants for a related cause. Transplant Services do not include other organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, except surgical implantation of an FDA approved Ventricular Assist Device (VAD), or total artificial heart, 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.

## **Y. 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](http://www.healthpartners.com) or by calling Member Services.

## V. 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 skills training.
2. 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, except as specified under the Home Hospice benefit. 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 (except for psychiatric residential treatment for emotionally disabled children, residential care for the treatment of eating disorders and chemical health treatment in a licensed residential primary treatment center as specified in the "Behavioral Health" section).
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. However, if a court orders an examination for a child, the initial examination will be covered. Court ordered treatment for behavioral health services will be covered consistent with the Claims Administrator's medical coverage criteria (available by logging onto your "myHealthPartners" account at [www.healthpartners.com](http://www.healthpartners.com) or by calling Member Services).
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 after reversal of sterilization; artificial insemination when not medically necessary for the treatment of a Covered Person's medically diagnosed infertility; and sperm, ova or embryo acquisition, retrieval or storage.
15. Services related to the establishment of surrogate pregnancy and fees for a surrogate.

16. Keratotomy and keratorefractive surgeries, eyeglasses, contact lenses and their fitting, measurement and adjustment, and hearing aids (implantable and external, including osseointegrated or bone anchored) and their fitting, except as specifically described in this 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](http://www.healthpartners.com) or by calling Member Services.
17. Medical Food. Enteral feedings, unless they are the sole source of nutrition used to treat a life-threatening condition, nutritional supplements, over-the-counter electrolyte supplements and infant formula, except as specified in this SPD. This exclusion does not apply to oral amino acid based elemental formula or other items if they meet HealthPartners medical coverage criteria.
18. Charges for sales tax.
19. Services provided by a family member of the Covered Person, or a resident in the Covered Person's home.
20. Religious counseling, marital/relationship counseling and sex therapy.
21. Private duty nursing services.
22. 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.
23. 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.
24. 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.
25. Travel and lodging incidental to travel, regardless if it is recommended by a physician and any travel billed by a provider.
26. Health club memberships.
27. Massage therapy for the purpose of a Covered Person's comfort or convenience.
28. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
29. Autopsies.
30. 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.
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 12 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, unless listed on the formulary and prescribed by a physician or legally authorized health care provider under applicable state law, including, but not limited to, vitamins, supplements, homeopathic remedies, and non-FDA approved drugs. This exclusion does not include over-the-counter contraceptives for women as allowed under the Affordable Care Act when the Covered Person obtains a prescription for the item.
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. Services provided by naturopathic providers.
37. Oral surgery to remove wisdom teeth.
38. Treatment, procedures, or services or drugs which are provided when you are not covered under this Plan.
39. Care that is not rehabilitative in nature and medically necessary for the diagnosis and/or treatment of acute neuromusculoskeletal conditions
40. Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

41. Non-medical administrative fees and charges including, but not limited to, medical record preparation charges, appointment cancellation fees, after hours appointment charges, and interest charges.
42. Medical cannabis.
43. Drugs on the Excluded Drug List. The Excluded Drug List includes select drugs within a therapy class that are not eligible for coverage.

## **VI. 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. In certain circumstances where prior authorization is required for a covered service, Covered Persons may be directed by the Plan Manager to the most cost-effective site of care to receive covered services. If the site to which the Covered Person is being directed has a higher cost to the Covered Person than the original physician directed site of care, the benefit category with the lower cost to the Covered Person will apply.

Covered prescription drugs are based on requirements established by the HealthPartners Pharmacy and Therapeutics Committee, and are subject to periodic review and modification.

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 33<sup>rd</sup> Avenue South, P.O. Box 1309

Minneapolis, MN 55440-1309

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

## VII. CONDITIONS

### A. COORDINATION OF BENEFITS

(for purposes of this section only quotation marks will be used for “plan” and “The Plan” to ensure clarity)

You agree, as a Covered Person, to permit the Claims Administrator 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 Claims Administrator'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 Covered Employee or the Covered Employee'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. (for purposes of this section only quotation marks will be used for “plan” and “The Plan” to ensure clarity)

- 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 calendar 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 Covered Employee who is neither laid off nor retired (or as that Covered Employee's dependent) are determined before those of a plan which cover that person as a laid off or retired Covered Employee (or as that Covered Employee'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 "The 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".
- c. **Benefit Reserve.** The Secondary Plan shall calculate its savings by subtracting the amount that it paid as a Secondary Plan from the amount it would have paid had it been primary "COB Savings". These COB Savings shall be recorded in the benefit reserve for the Covered Person and shall be used by the Secondary Plan to pay any allowable expenses, not otherwise paid, that are incurred by the Covered Person during the Claim Determination Period. As each claim is submitted, the Secondary Plan must:
  - (1) determine its obligation, pursuant to the contract;
  - (2) determine whether a benefit reserve has been recorded for the Covered Person; and
  - (3) determine whether there are any unpaid allowable expenses during that Claim Determination Period.

If there is a benefit reserve, the Secondary Plan shall use the Covered Person's recorded benefit reserve to pay up to 100% of the total allowable expenses incurred during the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero. A new benefit reserve must be created for each Claim Determination Period. (A Claim Determination Period is based on calendar year.)

- 5. Right to Receive and Release Needed Information.** Certain facts are needed to apply these COB rules. The Claims Administrator has the right to decide which facts are needed. Consistent with applicable state and federal law, the Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator's program to bill allowable no-fault and workers’ compensation claims to the appropriate insurer(s).

## **B. 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.

In general, 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.

Medicare is the primary payer:

1. 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.
2. For retirees who are age 65 or over.
3. 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.

If Medicare is the primary payer, 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.



If Medicare is the primary payer, 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.

If Medicare is the primary payer, the benefits under the Plan will only be reduced to the extent that the Covered Person has actually enrolled in Medicare.

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.

## **VIII. THIS SECTION LEFT INTENTIONALLY BLANK**

## **IX. 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. **Proof of Loss.** Claims for services must be submitted to the Claims Administrator 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 Claims Administrator, the deadline for claim submission is 180 days. The Claims Administrator 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

2. **Time of Payment of Claims.** Benefits will be paid under the Plan within a reasonable time period.

3. **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 Claims Administrator'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.
4. **Physical Examinations and Autopsy.** In the event the Claims Administrator or Plan Sponsor requires information from a physical exam or autopsy to properly resolve a claim dispute, the Claims Administrator 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.
5. **Clerical Error.** If a clerical error or other mistake occurs, that error does not 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 Claims Administrator, in accordance with the terms of this SPD and other Plan documents.

#### **C. TIME OF NOTIFICATION TO CLAIMANT OF 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 Claims Administrator 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, and such notification will include the reason the extension is needed and the date a determination can be expected.

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

#### **D. CLAIM DENIALS AND CLAIM APPEALS PROCESS FOR ALL CLAIMS**

If your 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. The applicable Appeals Administrator's review of a claim will not afford deference to the initial claim denial decision or any level-one appeal decision and will be made by someone other than, and not a subordinate of, the individual who made the adverse benefit determination.

You must exhaust the first and second levels of the appeal process prior to obtaining an external review or bringing a civil action under section 502(a) of ERISA. However, if the Plan does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") and may proceed with External Review or may pursue any available remedies under 502(a) of ERISA or under state law, as applicable. An exception to "Deemed Exhaustion" applies if the rule violation was (1) minor and not likely to influence a decision or harm you, (2) for good cause or beyond the control of the Plan or Claims Administrator or its designee, (3) part of an ongoing good faith exchange between you and the Plan or Claims Administrator or its designee, and (4) not part of a pattern or practice of violations by the Plan or Claims Administrator.

If the plan has denied an appeal for health benefits based on a medical judgment (e.g., medical necessity, experimental/investigational), the applicable Appeals Administrator will consult with a health care professional with appropriate training and experience in the relevant field, who is not the individual who was consulted in connection with the initial claim denial or level-one decision regarding the claim or a subordinate of such individual. In this case, you may be asked to complete a Release of Information (ROI) allowing the health care professional to review your medical records and contact your physician.

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 33<sup>rd</sup> 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.

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

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 Claims Administrator and submit issues, comments and additional information as appropriate to:

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

The Claims Administrator will review your appeal and will notify you of its decision within 30 days.

All notifications described above will comply with applicable law.

3. **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 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 Claims Administrator within four months of the adverse decision. Within five business days after HealthPartners receives your request for an external review, HealthPartners is required to review your request and determine if your request is eligible for external review. Within one business day after this, HealthPartners must notify you (or your authorized representative) in writing whether your request is complete and eligible. Within one business day after deciding your request is eligible, HealthPartners will assign an IRO to your claim, and notify you or your authorized representative in writing of the IRO's contact information.
- 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 Claims Administrator. Within five business days after the request for external review has been assigned to the Independent Review Organization, the Plan or Claims Administrator or its designee will provide the Independent Review Organization with the documents and any information considered in making the claim denial and appeal denial. If the Plan or Claims Administrator or its designee fails to timely provide the information, the Independent Review Organization may terminate the external review and reverse the claim or appeal denial in your favor.
- Within 10 business days of the Independent Review Organization's receipt of the request for external review, the Covered Person and the Claims Administrator 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 Claims Administrator 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.
- The Independent Review Organization will review all of the information and documents timely received and it will not be bound by any decisions or conclusions reached during the claims and internal appeals processes. The Independent Review Organization also will, to the extent the information and documents are available and the Independent Review Organization considers them appropriate, consider other sources of information including, but not limited to, your medical records, your health care professional's recommendations, the terms of the plan, appropriate practice guidelines, and clinical review criteria.
- An external review decision must be made as soon as possible, but no later than 45 days after receipt of the request for external review. The decision is binding on the Plan and the Covered Person. Prompt written notice of the decision and the reasons for it must be sent to the Covered Person and to the Claims Administrator. Upon receipt of a notice of a final External Review decision reversing the final adverse benefit determination, the plan will provide coverage or payment for the claim.