

WELCOME

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HealthPartners Primary Clinic Choice Schedule of Payments

Master Contractholder: eFunds & iDlx

Group Number: 14509

Effective Date: The later of January 1, 2004 and your effective date of coverage under the Master Group Contract.

See Section III. of the Membership Contract for a full description of coverage.

HealthPartners Benefits are underwritten by HealthPartners. Supplemental Benefits are underwritten by Midwest Assurance Company. The HealthPartners Benefits constitute a comprehensive plan. The Supplemental Benefits constitute a non-qualified plan.

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

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

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

Charge: For covered services delivered by participating network providers, or HealthPartners network referral providers, is the provider's discounted charge for a given medical/surgical service, procedure or item, which network providers have agreed to accept as payment in full.

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

The Fair and Reasonable Charge is the maximum amount allowed we consider in the calculation of payment of charges incurred for certain covered services. It is consistent with the charge of other providers of a given service or item in the same community, as defined by the Health Insurance Association of America (HIAA) schedule.

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

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

Copayment:

The specified dollar amount, or percentage, of charges incurred for covered services, which we do not pay, but which a member must pay, each time a member receives certain medical services, procedures or items. Our payment for those covered services or items begins after the copayment is satisfied. Covered services or items requiring a copayment are specified in this Contract.

For services provided by a network provider:

An amount which is listed as a flat dollar copayment is determined by a formula set forth in law which is based on the network provider's retail (undiscounted) charges for that service. However, if the network provider's discounted charge for a service or item is less than the flat dollar copayment, you will pay the network provider's discounted charge. An amount which is listed as a percentage of charges copayment is applied to the network provider's discounted charges for that service.

For services provided by a non-network provider:

Any copayment is applied to the lesser of the provider's charges and the fair and reasonable charge for a service.

A copayment is due at the time a service is provided, or when billed by the provider. The copayment applicable for a scheduled visit with a HealthPartners 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 we do not pay, but a member or a family has to pay first in a calendar year. Our payment for those services or items begins after the deductible is satisfied.

Deductible Carryover:

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

Lifetime Maximum Benefit:

The specified coverage limit paid for all charges combined and actually paid by us for a member under that coverage. Our payment ceases for that member, when that limit is reached. The member has to pay for subsequent charges.

Out-of-Pocket Expenses:

You pay the specified copayments and deductibles applicable for particular services, subject to the out-of-pocket limit described below. These amounts are in addition to the monthly enrollment payments.

Out-of-Pocket Limit:

You pay the copayments and deductibles for covered services, to the individual or family out-of-pocket limit. Thereafter we cover 100% of charges incurred for all other covered services, for the rest of the calendar year. You pay amounts greater than the out-of-pocket limit if any benefit maximums or the lifetime maximum are exceeded.

You are responsible to keep track of the out-of-pocket expenses. Contact our member services department for assistance in determining the amount paid by the enrollee for specific eligible services received.

	<u>HealthPartners Benefits</u>	<u>Supplemental Benefits</u>
Individual Calendar Year Deductible	None.	\$500
Family Calendar Year Deductible	None.	\$1,500
Individual Calendar Year Out-of-Pocket Limit	\$3,000	\$3,000
Family Calendar Year Out-of-Pocket Limit	\$5,000	\$5,000
	<i>The Out-of-Pocket Limits under the HealthPartners Benefits and the Supplemental Benefits are combined.</i>	
Lifetime Maximum Benefit	Unlimited.	\$1,000,000
	<i>Covered services provided under the HealthPartners Benefits apply toward the Lifetime Maximum Benefit under Supplemental Benefits.</i>	
A. AMBULANCE AND MEDICAL TRANSPORTATION		
Pre-authorized transfers between network hospitals for treatment if initiated by a network physician	80% of the charges incurred.	No Coverage.
All other eligible transportation	80% of the charges incurred.	80% of the charges incurred.
B. CHIROPRACTIC SERVICES		
	100% of the charges incurred, subject to a member copayment of \$15 per office visit.	80% of the charges incurred. Limit of 20 visits per calendar year.
C. DENTAL SERVICES		
Preventive Dental Services for members under age 19	100% of the charges incurred.	No Coverage.
	<i>Prophylaxis or periodontal maintenance recall are limited to twice per year. Bitewing x-rays are limited to once per year. Full mouth (panoramic) x-rays are limited to once every three years.</i>	
Accidental Dental Services		
a. Accidental Dental Services Within the Network	80% of the charges incurred.	No Coverage.

COVERED SERVICES

	<u>HealthPartners Benefits</u>	<u>Supplemental Benefits</u>
b. Emergency Accidental Dental Services Outside the Network	Subject to a deductible of \$50 per calendar year, and a maximum benefit of \$300, 80% of the charges incurred.	See HealthPartners benefit.
	<i>For all accidental dental services, treatment and/or restoration must be initiated within twelve months of the date of the injury. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration. Only services provided within twenty-four months from the date treatment or restoration was initiated are covered.</i>	
Medical Referral Dental Services		
a. Medically Necessary Outpatient Dental Services	100% of the charges incurred, subject to a member copayment of \$15 per office visit.	80% of the charges incurred.
b. Medically Necessary Hospitalization for Dental Care	See HealthPartners Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.	See Supplemental Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.
c. Medical Complications of Dental Care	100% of the charges incurred, subject to a member copayment of \$15 per office visit.	80% of the charges incurred.
Oral Surgery	100% of the charges incurred, subject to a member copayment of \$15 per office visit.	80% of the charges incurred.
Orthognathic Surgery Benefit	75% of the charges incurred.	No Coverage.
Treatment of Cleft Lip and Cleft Palate of a Dependent Child	100% of the charges incurred, subject to a member copayment of \$15 per office visit.	80% of the charges incurred.
Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD)	100% of the charges incurred, subject to a member copayment of \$15 per office visit.	80% of the charges incurred.

COVERED SERVICES

HealthPartners Benefits

Supplemental Benefits

D. DIAGNOSTIC IMAGING SERVICES

We cover 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)

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|--|-------------------------------|------------------------------|
| a. Outpatient Magnetic Resonance Imaging (MRI) and computing Tomography (CT) | 80% of the charges incurred. | 80% of the charges incurred. |
| b. All other outpatient diagnostic imaging services | 100% of the charges incurred. | 80% of the charges incurred. |

E. DURABLE MEDICAL EQUIPMENT, INCLUDING ORTHOTICS AND PROSTHETICS

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| 80% of the charges incurred. | 80% of the charges incurred. |
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No more than a 90-day supply of diabetic supplies are covered and dispensed at a time.

F. EMERGENCY AND URGENTLY NEEDED CARE SERVICES

Emergency and Urgently Needed Care Within the Network

Emergency and Urgently Needed care at network clinics	100% of the charges incurred, subject to a member copayment of \$15 per office visit.	No Coverage.
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Emergency care in a hospital emergency room, including professional services of a physician	100% of the charges incurred, subject to a member copayment of \$55 per visit.	No Coverage.
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Emergency room copayment is waived if admitted for the same condition within 24 hours.

Emergency and Urgently Needed Care Outside the Network

Professional services of a physician, urgent care treatment, emergency room treatment and inpatient hospital services	80% of the first \$2,500 and 100% thereafter of the charges incurred per calendar year.	See HealthPartners Benefits.
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COVERED SERVICES

	<u>HealthPartners Benefits</u>	<u>Supplemental Benefits</u>
G. HEALTH EDUCATION		
Provider office visit/session in connection with preventive services	100% of the charges incurred.	No Coverage.
Provider office visit/session in connection with the management of a chronic health problem (such as diabetes)	100% of the charges incurred, subject to a member copayment of \$15 per office visit.	No Coverage.
H. HOME HEALTH SERVICES		
Physical therapy, occupational therapy, speech therapy, respiratory therapy and home health aide services	100% of the charges incurred, subject to a member copayment of \$15 per visit. <i>If more than one home health visit occurs in a day, a separate copayment applies to each. For example, if a nurse and a physical therapist visit a member in the same day, a separate copayment will be charged for each visit.</i>	80% of the charges incurred.
TPN/IV therapy, skilled nursing services, prenatal and postnatal services, child health services and phototherapy	100% of the charges incurred.	80% of the charges incurred.
Maximum visits	Maximum of 120 visits per calendar year.	Maximum of 60 visits per calendar year.
	<i>Each day of services provided under the HealthPartners Benefits, and Supplemental Benefits counts toward the maximums shown above.</i>	
I. HOME HOSPICE SERVICES		
Part-time care	100% of the charges incurred.	No Coverage.
Continuous care	100% of the charges incurred.	No Coverage.
	<i>Limit of 30 days of continuous care and respite care combined.</i>	
Respite care	80% of the charges incurred.	No Coverage.
	<i>Respite care is limited to 5 days per episode, and 30 days of continuous care and respite care combined.</i>	
Medically necessary medications for pain and symptom management	100% of the charges incurred.	No Coverage.
Semi-electric hospital beds and other durable medical equipment	100% of the charges incurred.	No Coverage.

COVERED SERVICES

HealthPartners Benefits

Supplemental Benefits

Emergency and non-emergency care 100% of the charges incurred.

No Coverage.

J. HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Medical or Surgical Hospital Services

a. Inpatient Hospital Services	100% of the charges incurred. Limited to 365 day maximum per period of confinement, subject to the combined day limit.	80% of the charges incurred. Limited to 365 day maximum per period of confinement, subject to the combined day limit.
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Each member's admission or confinement, including that of a newborn child, is separate and distinct from the admission or confinement of any other member.

b. Outpatient Hospital, Ambulatory Care or Surgical Facility Services <i>(to see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see benefits under Diagnostic Imaging Services, Laboratory Services and Physical Therapy)</i>	100% of the charges incurred.	80% of the charges incurred.
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Skilled Nursing Facility Care	See HealthPartners Inpatient Hospital Services Benefit. Limited to 120 day maximum per period of confinement, subject to the combined day limit.	See Supplemental Inpatient Hospital Services Benefit. Limited to 120 day maximum per period of confinement, subject to the combined day limit.
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Each day of services provided under the HealthPartners Benefits applies toward the 120 day maximum for Supplemental Benefits.

K. INFERTILITY SERVICES	80% of the charges incurred.	80% of the charges incurred.
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L. LABORATORY SERVICES <i>We cover services provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)</i>	100% of the charges incurred.	80% of the charges incurred.
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M. MASTECTOMY RECONSTRUCTION BENEFIT	Coverage level is same as corresponding HealthPartners benefit, depending on type of service provided, such as Office Visits for Illness or Injury, or Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Supplemental benefit, depending on type of service provided, such as Office Visits for Illness or Injury, or Inpatient or Outpatient Hospital Services.
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N. MENTAL AND CHEMICAL HEALTH SERVICES

Mental Health Services

COVERED SERVICES

	<u>HealthPartners Benefits</u>	<u>Supplemental Benefits</u>
a. Outpatient Services, including family therapy	100% of the charges incurred, subject to a member copayment of \$15 per visit. For family therapy, only one member copayment will be charged, regardless of the number of members primarily involved in the therapy.	80% of the charges incurred for each of the first 10 hours of treatment, and 75% of the charges incurred, for the next 30 hours of treatment. Limited to maximum of 40 scheduled hours per calendar year.
Group Therapy	100% of the charges incurred, subject to a member copayment of \$7.50 per visit.	80% of the charges incurred. (Subject to the 40 hour limit shown in a. above)
<i>Any hours of treatment received under the HealthPartners Benefit apply toward the 40 hour maximum under Supplemental Benefits. "Hours of treatment" are provided on an individual or single-family basis. If treatment is provided on a group basis, two group therapy sessions count as one hour of treatment.</i>		
b. Inpatient Services, including Day Treatment Services	See HealthPartners Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.	See Supplemental Inpatient Hospital Services Benefit. Limited to 30 day maximum per calendar year, subject to the combined day limit.
<i>Each day of services provided under the HealthPartners Benefits applies toward the 30 day maximum for Supplemental Benefits. More than three hours per day in a day treatment program provided under the HealthPartners Benefits and Supplemental Benefits counts as a half day toward the day maximum shown above and the combined day limit, for the same period of confinement.</i>		

COVERED SERVICES

HealthPartners Benefits

Supplemental Benefits

Chemical Health Services

a. Outpatient Services

100% of the charges incurred, subject to a member copayment of \$15 per visit.

80% of the charges incurred. Limited to a maximum of 130 hours of treatment per calendar year.

For family therapy, only one member copayment will be charged, regardless of the number of members primarily involved in the therapy.

We cover the overnight stay at a contracted organization for members actively involved in an affiliated licensed chemical dependency day treatment program for treatment of alcohol or drug abuse.

Any hours of treatment received under the HealthPartners Benefits apply toward the 130 hour maximum under Supplemental Benefits.

b. Inpatient Services, including Day Treatment Services

See HealthPartners Inpatient Hospital Services Benefit.

See Supplemental Inpatient Hospital Services Benefit.

Limited to 365 day maximum per period of confinement, subject to the combined day limit.

Limited to 73 day maximum per calendar year, subject to the combined day limit.

Each day of services provided under the HealthPartners Benefits applies toward the 73 day maximum for Supplemental Benefits. More than three hours per day in a day treatment services program provided under the HealthPartners Benefits and Supplemental Benefits counts as a half day toward the day maximum shown above and toward the combined day limit, for the same period of confinement.

O. OFFICE VISITS FOR ILLNESS OR INJURY

100% of the charges incurred, subject to a member copayment of \$15 per office visit.

80% of the charges incurred.

P. PHYSICAL THERAPY AND OCCUPATIONAL THERAPY

We cover services provided in a clinic. We also cover 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 Care

100% of the charges incurred, subject to a member copayment of \$15 per visit.

80% of the charges incurred. Limit of 20 visits per calendar year.

COVERED SERVICES

	<u>HealthPartners Benefits</u>	<u>Supplemental Benefits</u>
Habilitative Care	100% of the charges incurred, subject to a member copayment of \$15 per visit.	No Coverage.
SPEECH THERAPY		
Rehabilitative Care	100% of the charges incurred, subject to a member copayment of \$15 per office visit.	80% of the charges incurred. Limit of 20 visits per calendar year.
Habilitative Care	100% of the charges incurred, subject to a member copayment of \$15 per office visit.	No Coverage.
Q. PRESCRIPTION DRUG SERVICES		
Outpatient drugs	100% of the charges incurred, subject to a member copayment of \$11. <i>Drugs for the treatment of sexual dysfunction are limited to six doses per month.</i>	80% of the charges incurred. <i>Drugs for the treatment of sexual dysfunction are not covered.</i>
Tobacco cessation products, as determined by HealthPartners. Must be prescribed by a licensed provider and filled at a network pharmacy. Limited to a 180-day supply per calendar year. No more than a 30-day supply will be covered and dispensed at a time.	See Outpatient drugs benefit.	No Coverage.
Mail Order Drugs	You may also get outpatient formulary 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 90-day supply, or portion thereof, or for three manufacturer's pre-packaged dispensing units, if applicable.	See HealthPartners Benefit

COVERED SERVICES

HealthPartners Benefits

Supplemental Benefits

For your convenience, you may also order insulin, infertility drugs and growth hormones through the mail order service without a discounted benefit. For information on how to obtain drugs through HealthPartners mail order service, refer to your enrollment material.

Injections administered in a physician's office

Allergy injections	100% of the charges incurred.	80% of the charges incurred.
Immunizations	100% of the charges incurred.	No Coverage.
All other injections	100% of the charges incurred.	80% of the charges incurred.

Injectable and implantable birth control drugs/devices (Implantable drugs/devices are limited to one every five years.)

80% of the charges incurred. 80% of the charges incurred.

Growth hormone therapy

80% of the charges incurred. 80% of the charges incurred.

Special dietary treatment for Phenylketonuria (PKU)

80% of the charges incurred. 80% of the charges incurred.

Drugs for treatment of infertility

80% of the charges incurred. 80% of the charges incurred.

Unless otherwise specified in this section, you may receive up to a 30-day supply per prescription. No more than a 90-day supply will be covered and dispensed at a time. We have written guidelines and procedures for granting an exception to the formulary that are available to you upon request. If there is a generic equivalent, brand name drugs are only covered up to the charge that would apply to the generic drug, minus any required copayment. If a member copayment is required, you must pay one member copayment for each 30-day supply, or portion thereof, or for each manufacturer's pre-packaged dispensing unit, if applicable, except as follows:

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

For contraceptive barrier devices, a copayment will apply per device.

For Mail Order Drugs, see benefit above.

R. PREVENTIVE SERVICES

Routine health exams and periodic health assessments	100% of the charges incurred.	No Coverage.
Child health supervision services	100% of the charges incurred.	No Coverage.
Prenatal services	100% of the charges incurred.	80% of the charges incurred.

COVERED SERVICES

	<u>HealthPartners Benefits</u>	<u>Supplemental Benefits</u>
Postnatal services	100% of the charges incurred.	80% of the charges incurred.
Routine screening procedures for cancer	100% of the charges incurred.	80% of the charges incurred.
Routine eye and hearing exams	100% of the charges incurred.	No Coverage.
Professional voluntary family planning services	100% of the charges incurred.	No Coverage.
Adult immunization	100% of the charges incurred.	No Coverage.
S. SPECIFIED NON-NETWORK SERVICES	Coverage level is same as corresponding HealthPartners benefit, depending on type of service provided, such as Office Visits for Illness or Injury.	See HealthPartners Coverage for the services covered.
T. TRANSPLANT SERVICES	See HealthPartners Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.	See Supplemental Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.

Amendment to HealthPartners Primary Clinic Choice Group Membership Contract

Keep this Amendment with your Group Membership Contract

Master Contractholder: eFunds
Group Number: 14509
Effective Date: The later of January 1, 2003 and your effective date for coverage under the Master Group Contract.

Your Group Membership Contract is amended as follows:

In Section II. "DEFINITIONS OF TERMS USED", the definition of "Eligible Dependents" is amended by adding a new item 5. "Domestic Partner" as follows:

- "5. **Domestic Partner.** This is an enrollee's spousal equivalent, provided the enrollee and the domestic partner:
- (a) share the same regular and permanent residence; and
 - (b) are jointly responsible for basic living expenses; and
 - (c) are not married to anyone and have been each other's sole domestic partner for at least six months; and
 - (d) are each 19 years of age or older; and
 - (e) are each mentally competent to consent to a contract; and
 - (f) have completed the form required by the group health plan sponsor for coverage of a domestic partner and have agreed to any conditions specified in that form.

After terminating a partnership, there will be a twelve-month waiting period to cover the same partner again or a new partner. An enrollee may also enroll the eligible dependent child(ren) of his or her domestic partner for coverage under this contract, so long as the child meets the definition of unmarried step-child of the enrollee (that is the unmarried child of the enrollee's domestic partner) and the domestic partner remains eligible and enrolled. Domestic partners and their eligible dependent children are eligible for continuation and conversion coverage under this Contract."

Amendment to HealthPartners Primary Clinic Choice Group Membership Contract

Keep this Amendment with your Group Membership Contract

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

Your Group Membership Contract is amended as follows:

1. In section I. "INTRODUCTION TO THE GROUP MEMBERSHIP CONTRACT", J. "How To Use The Networks", "About the HMO Network", in Referrals and Authorizations for HealthPartners Services, the fourth and fifth paragraphs are replaced as follows:

"When an authorization for a service is required, we will make an initial determination within 15 calendar days, so long as all information reasonably needed to make the decision has been provided. This time period may be extended for an additional 15 calendar days.

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

2. In section I. "INTRODUCTION TO THE GROUP MEMBERSHIP CONTRACT", J. "How To Use The Network", About the HealthPartners Network, in Referrals and Authorizations for HealthPartners Services, the eighth paragraph is replaced as follows:

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

3. In section I. "INTRODUCTION TO THE GROUP MEMBERSHIP CONTRACT", K. CARECHECKsm, item 6. Pre-certification Process is replaced by the following:

"6. Pre-certification Process.

When certification is required, we will make an initial determination within 15 calendar days, so long as all information reasonably needed to make the decision has been provided.

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

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

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

4. In section V. “DISPUTES AND COMPLAINTS”, B. “Complaints”, subsection 3. “Complaint and Appeal Process” is replaced by the following:

3. Complaint and Appeal Process

a. Informal Complaints:

A complainant may submit a complaint to the Member Services Department either in writing or orally. Member Services will make every effort to resolve the complaint. The Member Services Department will investigate the complaint and provide for informal discussions. If the oral complaint is not resolved to the complainant's satisfaction within 10 calendar days of receipt of the complaint, we will provide a complaint form to the complainant, which must be completed and returned to the Member Services Department for further consideration. We will assist the complainant in completing this form, or will complete the form and mail it to the complainant for a signature, if the complainant asks for assistance.

At any time, the complainant may also file a complaint with the Commissioner of Health regarding network benefits, either in writing or by calling (651) 282-5608, or toll-free 1-800-657-3916 or the Commissioner of Commerce regarding Supplemental benefits at (651) 296-2488, or toll-free at 1-800-657-3602.

b. Formal Complaint and Appeal Process:

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

1. **Formal Complaint Review.** You or your authorized representative may send your written request for review, including comments, documents, records and other information relating to the complaint, the reasons you believe you are entitled to benefits, and any supporting documents to:

HealthPartners/Midwest Assurance Company
Member Services Department
8100 34th Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: (952) 883-5000 Outside the metro area: 1-800-883-2177
TDD Telephone Number: (952) 883-5127

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

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

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

Pre-Service Claims (services for which prior approval by us is a requirement for coverage).

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

If the complaint concerns non-urgent services, a decision on your complaint will be made within 30 calendar days.

These time periods may be extended if you agree.

Post-Service Claims.

A decision on your complaint will be made within 30 calendar days. This time period may be extended if you agree.

All notifications described above will comply with applicable law.

2. **Appeal.** If after the first level of complaint review of a post-service claim, your request was denied, you or your authorized representative may submit a written request for appeal, including any relevant documents, and submit issues, comments and additional information as appropriate to:

HealthPartners/Midwest Assurance Company
Member Services Department
8100 34th Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: (952) 883-5000 Outside the metro area: 1-800-883-2177
TDD Telephone Number: (952) 883-5127

The Member Services Department will provide the complainant with the option of either a written reconsideration, or a hearing before the Member Appeals Committee either in person or over the phone. Hearings and written reconsiderations shall include the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, providers, or other persons, as is deemed necessary for a fair appraisal and resolution of the complaint. During your appeal, upon your request we will provide you, free of charge, reasonable access to all documents, records and other information relevant to your appeal.

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

These time periods may be extended if you agree.

5. In section V. "DISPUTES AND COMPLAINTS", B. "Complaints", subsection 4. "External Complaint Procedures", item b. is replaced by the following:
 - "b. To initiate the external review process, you may submit a written request for an external review to the Commissioner of Health (Commissioner of Commerce). This written request must be accompanied by a \$25 filing fee payable to the Center for Health Dispute Resolution. This fee may be waived by the Commissioner in cases of financial hardship. We must participate in this external review, and must pay the cost of the review which exceeds the \$25 filing fee."

Amendment to HealthPartners Primary Clinic Choice Group Membership Contract

Keep this Amendment with your Group Membership Contract

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

Your Group Membership Contract is amended as follows:

1. In Section I. "INTRODUCTION TO THE GROUP MEMBERSHIP CONTRACT", J. "How to Use the Network", the fifth paragraph is changed as follows:

"A provider listing will be sent to you automatically, and free of charge, as a separate document along with the Membership Contract.

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

2. In Section I. "INTRODUCTION TO THE GROUP MEMBERSHIP CONTRACT", L. "Access to Records and Confidentiality" is replaced by the following:

"L. ACCESS TO RECORDS AND CONFIDENTIALITY

We comply with the state and federal laws governing the confidentiality and use of protected health information and medical records. As part of this Contract, we are authorized to have access to and use protected health information held by any health care provider who delivers health care services to you under this Contract. We are also allowed to use your protected health information, when necessary, for certain health care operations, including, but not limited to: claims processing, including claims we make for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, case management, care coordination and utilization management, disease management, underwriting; premium rating, claims experience reporting to your employer or other health plan sponsor; (only upon certification by your employer or plan sponsor of the compliance of plan documents with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")), the evaluation of potential or actual claims against us, auditing and legal services, and other access and use without further authorization if permitted or required by another law."

3. In section II. "DEFINITIONS OF TERMS USED":

- A. In the definition of "Eligible Dependents", the following sentence is added to the end of item 2. "Child":

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

- B. The definition of "Formulary" is replaced by the following:

"Formulary: This is a current list, which may be revised from time to time, of prescription drugs, equipment and supplies covered by us as indicated in the Schedule of Payments. We have written guidelines and procedures for granting an exception to the formulary that is available to you upon request. These guidelines and procedures include exceptions to the formulary for anti-psychotic drugs prescribed to treat emotional disturbances or mental illness and your right to receive certain non-formulary drugs for diagnosed mental illness or emotional disturbance when our formulary changes or you change health plans. The formulary is available by calling Member Services, or on our web site at www.healthpartners.com."

4. In section III. “DESCRIPTION OF COVERED SERVICES”, D. “DURABLE MEDICAL EQUIPMENT, ORTHOTICS AND PROSTHETICS”:

A. The first paragraph of item 1. is replaced by the following:

“Durable medical equipment and orthotic benefits, including certain disposable supplies, enteral feedings and the following diabetic supplies and equipment as listed on the formulary: glucose monitors, insulin pumps, syringes, blood and urine test strips and other diabetic supplies as deemed medically appropriate and necessary, for members with gestational, Type I or Type II diabetes.”

B. The last paragraph in section D. is replaced by the following:

“Covered services and supplies are based on established medical policies and the formulary, which are subject to periodic review and modification by the medical or dental directors. These medical policies (medical coverage criteria) are available by calling Member Services, or on our web site at www.healthpartners.com.”

5. In section III. “DESCRIPTION OF COVERED SERVICES”, M. “MENTAL AND CHEMICAL HEALTH SERVICES”:

A. In 1. “Mental Health Services, b. “Inpatient Services (including Day Treatment)”, the second paragraph is replaced by the following:

“We cover day treatment services in a hospital or licensed residential psychiatric treatment facility and professional services for treatment of mental and nervous disorders.”

B. The heading for item 3. “Hospital or Residential Treatment Facility Care for Emotionally Handicapped Children” is replaced by . “Hospital or Residential Psychiatric Treatment Facility Care for Emotionally Handicapped Children”.

6. In section VI. “CONDITIONS”:

A. In subsection A. “Rights of Reimbursement and Subrogation”, the third paragraph is replaced by the following:

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

B. In subsection C. “Medicare and This Contract”, the second paragraph is replaced by the following:

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

7. Sections XI. "STATEMENT OF ERISA RIGHTS" and XII. "SPECIFIC INFORMATION ABOUT THE PLAN" are added as follows:

XI. STATEMENT OF ERISA RIGHTS

Federal law and regulations require that this "Statement of ERISA Rights" be included in this Group Membership Contract. ERISA rights are in addition to any rights you may also have under state law; however, federal law may not invalidate, impair or supercede state law.

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

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

Prudent actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance With Your Questions

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

XII. SPECIFIC INFORMATION ABOUT THE PLAN

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

Name of the Plan:	See your employer's plan documents.
Address of the Plan:	See your employer's plan documents.
IRS Employer Identification Number:	See your employer's plan documents.
Plan Identification Number:	See your employer's plan documents.
Plan Year:	See your employer's plan documents.
Plan Fiscal Year Ends:	See your employer's plan documents.
Plan Administrator:	Your employer.
Agent for Service of Legal Process:	For this Group Membership Contract's benefits: HealthPartners For all other matters: your employer.

Named Fiduciary:	For this Group Membership Contract's benefits: HealthPartners For all other matters: your employer.
Funding:	This Group Membership Contract is fully insured under Minnesota law.
Network Providers:	HealthPartners Network
Contributions:	Employer and Employee. For more details, see your employer's enrollment materials.
Employment Waiting Period:	See your employer's plan documents.
Eligible Classes:	See your employer's plan documents.

Amendment to HealthPartners Primary Clinic Choice Group Membership Contract

Keep this Amendment with your Group Membership Contract

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

Your Group Membership Contract is amended as follows:

- A. In I. "INTRODUCTION TO THE GROUP MEMBERSHIP CONTRACT", J. "How To Use the Network", "About the HealthPartners Network", "Referrals and Authorizations for HealthPartners Services", the fourth paragraph is replaced by the following:

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

- B. In I. "INTRODUCTION TO THE GROUP MEMBERSHIP CONTRACT", K. "CareCheck", 6. "Pre-certification Process", the first paragraph is replaced by the following:

"When certification is required, we will make an initial determination within 14 calendar days, so long as all information reasonably needed to make the decision has been provided."

- C. In I. "INTRODUCTION TO THE GROUP MEMBERSHIP CONTRACT", L. "Access to Records and Confidentiality" is replaced by the following:

"L. ACCESS TO RECORDS AND CONFIDENTIALITY

We comply with the state and federal laws governing the confidentiality and use of protected health information and medical records. When your provider releases health information to us according to state law, we can use your protected health information, when necessary, for certain health care operations, including, but not limited to: claims processing, including claims we make for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, case management, care coordination and utilization management, disease management, underwriting; premium rating, claims experience reporting to your employer or other health plan sponsor; (only upon certification by your employer or plan sponsor of the compliance of plan documents with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")), the evaluation of potential or actual claims against us, auditing and legal services, and other access and use without further authorization if permitted or required by another law."

- D. The following subsection D. "Diagnostic Imaging Services" is added to section III. "DESCRIPTION OF COVERED SERVICES", and subsequent subsections are relettered accordingly:

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

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

E. Item 3. “Authorized Care Outside the Service Area” is deleted from section III. “DESCRIPTION OF COVERED SERVICES”, subsection F. “Emergency and Urgently Needed Care Services”.

F. In section III. “DESCRIPTION OF COVERED SERVICES”, subsection H. “Home Health Services” is replaced by the following:

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

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

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. We will not reimburse family members or residents in the member's home for the above services.

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

G. In section III. “DESCRIPTION OF COVERED SERVICES”, subsection J. “Hospital and Skilled Nursing Facility Services”, 1. “Medical and Surgical Hospital Services”:

1. The following two paragraphs are added to a. “Inpatient Hospital Services”:

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

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

not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).”

2. **The following sentence is added to the third paragraph of 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 in the Schedule of Payments.”

- H. **In section III. “DESCRIPTION OF COVERED SERVICES”, subsection L. “Laboratory and Diagnostic Imaging Services” is replaced by the following:**

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

- I. **In section III. “DESCRIPTION OF COVERED SERVICES”, subsection N. “Mental and Chemical Health Services”, 1. “Mental Health Services”, b. “Inpatient Services (including Day Treatment)”, the following sentence is added to the end of the first paragraph:**

“Medical stabilization is covered under inpatient hospital services in the “Hospital and Skilled Nursing Facility Services” section.”

- J. **In section III. “DESCRIPTION OF COVERED SERVICES”, subsection R. “Preventive Services”, the following second paragraph is added:**

“Covered services are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. These medical policies (medical coverage criteria) are available by calling Member Services, or on our web site at www.healthpartners.com.”

- K. **In section IV. “SERVICES NOT COVERED”, items 1., 3., 4., 6., 11. and 25. are replaced as follows:**

“1. Treatment, procedures, or services or drugs which are not medically necessary and/or which are primarily educational in nature or for the vocation, comfort, convenience, appearance or recreation of the member, including cognitive retraining and skills training.

3. Procedures, technologies, treatments, facilities, equipment, drugs and devices which are considered investigative, or otherwise not clinically accepted medical services. We consider the following transplants to be investigative and do not cover them: surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, non-human organ implants and/or transplants and other transplants not specifically listed in this Contract. While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered. We consider intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders, including, but not limited to ABA, IEIBT and Lovaas, to be investigational and do not cover them.

4. Rest, respite and custodial care. This applies to all types of institutional care and to services, medical equipment and drugs provided in the home, such as Rule 1, 8, 36 and 203 facilities as defined by the Minnesota Department of Human Services or comparable facilities.

6. 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.

11. Health services and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise medically necessary. However, if a court orders an examination for a child, the initial examination will be covered. Court ordered treatment for mental health services will be covered by the benefits available under this contract when the court order complies with the requirements of Minnesota Statute 253B.045, subd.6 and 62Q.535.
25. The portion of a billed charge for an otherwise covered service by a non-network provider, which is in excess of the fair and reasonable charges. We also do not cover charges or a portion of a charge which is either a duplicate charge for a service or charges for a duplicate service.”

L. In section V. “DISPUTES AND COMPLAINTS”, B. “Complaints”, item 3. “Complaint and Appeal Process” is replaced by the following:

“3. Complaint and Appeal Process

a. Complaints:

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

At any time, the complainant may also file a complaint with the Commissioner of Health regarding network benefits, either in writing or by calling (651) 282-5600, or toll-free 1-800-657-3916 or the Commissioner of Commerce regarding Supplemental benefits at (651) 296-2488, or toll-free at 1-800-657-3602.

b. Appeal Process:

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

3. **First Level Appeal.** You or your authorized representative may send your written request for review, including comments, documents, records and other information relating to the appeal, the reasons you believe you are entitled to benefits, and any supporting documents to:

HealthPartners/Midwest Assurance Company
Member Services Department
8100 34th Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: (952) 883-5000 Outside the metro area: 1-800-883-2177
TDD Telephone Number: (952) 883-5127

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

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

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

Pre-Service Claims (services for which prior approval by us is a requirement for coverage).

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

If the appeal concerns non-urgent services, a decision on your appeal will be made within 30 calendar days.

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

Post-Service Claims.

A decision on your appeal will be made within 30 calendar days. This time period may be extended for up to 14 days if you agree.

All notifications described above will comply with applicable law.

- 4. Second Level Appeal.** If your request was denied after the first level appeal of a pre-service claim, you have the right to request external review of our decision. See below for a description of this process. If your request was denied after the first level appeal of a post-service claim, you or your authorized representative may submit a written request for a second level appeal, including any relevant documents, and submit issues, comments and additional information as appropriate to:

HealthPartners/Midwest Assurance Company
Member Services Department
8100 34th Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: (952) 883-5000 Outside the metro area: 1-800-883-2177
TDD Telephone Number: (952) 883-5127

The Member Services Department will provide the complainant with the option of either a written reconsideration, or a hearing before the Member Appeals Committee either in person or over the phone. Hearings and written reconsiderations shall include the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, providers, or other persons, as is deemed necessary for a fair appraisal and resolution of the appeal. During your appeal, upon your request we will provide you, free of charge, reasonable access to all documents, records and other information relevant to your appeal.

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

These time periods may be extended if you agree.”

M. In section VI. "CONDITIONS", in the first paragraph of A. "Rights of Reimbursement and Subrogation", the first sentence of the first paragraph is replaced as follows:

"If we provide or pay for services to treat an injury or illness: (a) caused by the act or omission of another party; or (b) covered by no fault or employer liability laws; or (c) available or required to be furnished by or through national or state governments or their agencies; or (d) sustained on the property of a third party, we have the right to recover the reasonable value of our services and payments made."

N. In section VI. "CONDITIONS", C. "Medicare and This Contract", the sixth paragraph is replaced by the following:

"The benefits under this Contract are considered secondary to those under Medicare if the member is eligible for Medicare. A member is eligible for Medicare Part A if the member is covered under the program. A member is eligible for Medicare Part B with respect to Medicare Part B, regardless of whether the member:

1. has Medicare Part B coverage;
2. has refused Medicare Part B coverage;
3. has dropped Medicare Part B coverage; or
4. has failed to make proper request for Medicare Part B coverage."

Amendment to HealthPartners Primary Clinic Choice Group Membership Contract

Keep this Amendment with your Group Membership Contract

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

Your Group Membership Contract is amended as follows:

A. In section II. “DEFINITION OF TERMS USED”, the definition of “Formulary” is replaced by the following:

“Formulary: This is a current list, which may be revised from time to time, of prescription drugs, medications, equipment and supplies covered by us as indicated in the Schedule of Payments. We have written guidelines and procedures for granting an exception to the formulary that is available to you upon request. These guidelines and procedures include exceptions to the formulary for anti-psychotic prescription drugs prescribed to treat emotional disturbances or mental illness and your right to receive certain non-formulary prescription drugs for diagnosed mental illness or emotional disturbance when our formulary changes or you change health plans. The formulary is available by calling Member Services, or on our web site at www.healthpartners.com.”

B. In section III. “DESCRIPTION OF COVERED SERVICES”, subsection E. “Durable Medical Equipment, Orthotics and Prosthetics” is replaced by the following:

“E. DURABLE MEDICAL EQUIPMENT, INCLUDING ORTHOTICS AND PROSTHETICS. We cover equipment and services, as described below.

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

Hearing aids for members age 18 or younger who have hearing loss due to functional congenital malformation of the ears 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 (subject to \$350 maximum payment per calendar year) and oral appliances for cleft lip and cleft palate, payment will not exceed the cost of an alternate piece of equipment or service that is effective and medically necessary and enables members to conduct standard activities of daily living.
 - c. We reserve the right to determine if an item will be approved for rental vs. purchase.
3. Items which are not eligible for coverage include, but are not limited to:
 - a. Replacement or repair of any covered items, if the items are (i) damaged or destroyed by member misuse, abuse or carelessness, (ii) lost; or (iii) stolen.
 - b. Duplicate or similar items.
 - c. Labor and related charges for repair of any covered items which are more than the cost of replacement by an approved vendor.
 - d. Sales tax, mailing, delivery charges, service call charges.
 - e. Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience or recreation.
 - f. Communication aids or devices: equipment to create, replace or augment communication abilities including, but not limited to, hearing aids, fitting of hearing aids, speech processors, receivers, communication boards, or computer or electronic assisted communication, except as described in this Contract.

- g. Household equipment which primarily has customary uses other than medical, such as, but not limited to, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds.
- h. Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas.
- i. Modifications to the structure of the home including, but not limited to, its wiring, plumbing or charges for installation of equipment.
- j. Vehicle, car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier.
- k. Rental equipment while member's owned equipment is being repaired, beyond one month rental of medically necessary equipment.
- l. Other equipment and supplies, including but not limited to assistive devices, that we determine are not eligible for coverage.

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

Covered services and supplies are based on established medical policies and the formulary, which are subject to periodic review and modification by the medical or dental directors. These medical policies (medical coverage criteria) are available by calling Member Services, or on our web site at www.healthpartners.com.”

C. In section III. “DESCRIPTION OF COVERED SERVICES”, subsection T. “Transplant Services”, “What is covered” is replaced by the following:

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

- 1. Kidney transplants for end-stage disease.
- 2. Cornea transplants for end-stage disease.
- 3. Heart transplants for end-stage disease.
- 4. Lung transplants or heart/lung transplants for: (1) primary pulmonary hypertension; (2) Eisenmenger's syndrome; (3) end-stage pulmonary fibrosis; (4) alpha 1 antitrypsin disease; (5) cystic fibrosis; and (6) emphysema.
- 5. Liver transplants for: (1) biliary atresia in children; (2) primary biliary cirrhosis; (3) post-acute viral infection (including hepatitis A, hepatitis B antigen e negative and hepatitis C) causing acute atrophy or post-necrotic cirrhosis; (4) primary sclerosing cholangitis; and (5) alcoholic cirrhosis; and (6) hepatocellular carcinoma.
- 6. Allogeneic bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for: (1) acute myelogenous leukemia; (2) acute lymphocytic leukemia; (3) chronic myelogenous leukemia; (4) severe combined immunodeficiency disease; (5) Wiskott-Aldrich syndrome; (6) aplastic anemia; (7) sickle cell anemia; (8) non-relapsed or relapsed non-Hodgkin’s lymphoma; (9) multiple myeloma; and (10) testicular cancer.
- 7. Autologous bone marrow transplants or peripheral stem cell support associated with high-dose chemotherapy for: (1) acute leukemias; (2) non-Hodgkin's lymphoma; (3) Hodgkin's disease; (4) Burkitt's lymphoma; (5) breast cancer stages II, III and IV, (6) neuroblastoma; (7) multiple myeloma; (8) chronic myelogenous leukemia; and (9) 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.”

D. In section IV. “SERVICES NOT COVERED”, items 16 and 29 are replaced by the following:

- “16. Keratotomy and keratorefractive surgeries, eyeglasses, contact lenses and their fitting, measurement and adjustment , and hearing aids and their fitting, except as specifically described in this Contract.
- 29. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.”

E. In section IV. “SERVICES NOT COVERED”, item 34 is added as following:

- “34. 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.”

F. In section X. "CLAIMS PROVISIONS, item 3 is replaced by the following:

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

G. In section XI. "STATEMENT OF ERISA RIGHTS", all references to the "Pension and Welfare Benefit Administration" are replaced by "Employee Benefits Security Administration".

