HealthPartners
UnityPoint Health

HealthPartners UnityPoint Health
Group Certificate
Small Employer Plan

Please save for future reference

MGC-900.2-HPUPH
SE-24

HealthPartners UnityPoint Health

Becky Woody
President

Statement of Nondiscrimination for Health Plan Members

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

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

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

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

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

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

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

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

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

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BENEFITS CHART Pr. 10/23

ABOUT HEALTHPARTNERS UNITYPOINT HEALTH

HealthPartners UnityPoint Health, Inc. (HealthPartners UnityPoint Health). HealthPartners UnityPoint Health is the insurance company underwriting the benefits described in this Certificate. When used in this Certificate, "we", "us" or "our" has the same meaning as "HealthPartners UnityPoint Health".

HealthPartners, Inc. (HealthPartners). HealthPartners is a non-profit corporation which is licensed by the State of Minnesota as a Health Maintenance Organization (HMO). HealthPartners administers the benefits described in this Certificate. HealthPartners is the parent company of a family of related organizations and provides administrative services for HealthPartners UnityPoint Health.

UnityPoint Health. UnityPoint Health is an Iowa non-profit corporation and care delivery system.

The coverage described in this Certificate and the Benefits Chart may not cover all your health care expenses. Read these documents carefully to determine which expenses are covered.

IMPORTANT CONSUMER INFORMATION

- You have the right to a grace period of 31 days for each enrollment payment due, when falling due after the first enrollment payment, during which period the Certificate shall continue in force
- Enrollees on Medicare have the right to voluntarily disenroll from HealthPartners UnityPoint Health and the right not to be requested or encouraged to disenroll, except in circumstances specified in federal law
- Certain services or medical or dental supplies are not covered. Read the Benefits Chart for a detailed explanation of exclusions
- You may continue coverage under certain circumstances. Read this Certificate for a description of your continuation rights
- Your coverage may be cancelled by you or us only under certain conditions. Read this Certificate for the reasons for cancellation of coverage

TERMS AND CONDITIONS OF USE OF THIS CERTIFICATE

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

HealthPartners UnityPoint Health Marks. The HealthPartners UnityPoint Health name and logo and all related products and service names and design marks are used under a license agreement with HealthPartners, Inc. and UnityPoint Health.

INTRODUCTION TO THE GROUP CERTIFICATE

GROUP CERTIFICATE

This Group Certificate (this Certificate) is the Enrollee's evidence of coverage, under the Group Policy issued by HealthPartners UnityPoint Health to the Enrollee's Group Health Plan Sponsor. The Group Policy provides for the medical and dental coverage described in this Certificate. It covers the Enrollee and the enrolled Dependents (if any) as named on the Enrollee's application. This Certificate replaces all certificates previously issued by us.

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

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

IDENTIFICATION CARD

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

ASSIGNMENT OF BENEFITS

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

ENROLLMENT PAYMENTS

This Certificate is conditioned on our regular receipt of Enrollees' enrollment payments. The enrollment payments are made through the Enrollee's Group Health Plan Sponsor, unless we have agreed to another payment method. Enrollment payments are based upon the certificate type and the number and status of any dependents enrolled with the Enrollee.

Please refer to the most recent enrollment material for information regarding contributions to your plan which is hereby incorporated by this reference.

BENEFITS

This Certificate provides **Network Benefits** underwritten by HealthPartners UnityPoint Health, Inc., when you seek medical or dental services delivered by participating Network Providers.

This Certificate describes your Network Benefits and how to obtain Covered Services.

This Certificate provides **Out-of-Network Benefits**, underwritten by HealthPartners UnityPoint Health, Inc., for medical or dental services delivered by Out-of-Network Providers.

See the Benefits Chart for a description of Covered Services, coverage limitations, and exclusions. The fact that an authorized Network or Out-of-Network Provider prescribes treatment does not necessarily mean the treatment is covered under this Certificate.

Applicable to Out-of-Network Benefits.

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

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

HealthPartners UnityPoint Health wants you to get the most out of your health plan and help you live healthier. From time to time, HealthPartners UnityPoint Health may provide access to additional benefits, healthy discounts and rewards to encourage engagement with health plan benefits. These additional benefits, discounts, and rewards are not considered insurance and may be altered or discontinued at any time. To learn more about programs that may be available, log on to your account at HealthPartnersUnityPointHealth.com.

BENEFITS CHART

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

AMENDMENTS TO THIS CERTIFICATE

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

GROUP POLICY

The HealthPartners UnityPoint Health Group Policy combined with this Certificate, Benefits Chart, any Amendments, the Group Health Plan Sponsor's application, the individual applications of the Enrollees and any other document referenced in the Group Policy constitute the entire contract between HealthPartners UnityPoint Health and the Group Health Plan Sponsor. This Group Policy is available for inspection at your Group Health Plan Sponsor's office or at HealthPartners UnityPoint Health's home office, at HealthPartners UnityPoint Health, Inc., 3737 Woodland Avenue, Suite 310, West Des Moines, IA 50266. The Group Policy is delivered in the State of Iowa and governed by the laws thereof.

CONFLICT WITH EXISTING LAW

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

HOW TO USE THE NETWORK

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

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

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

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

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

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

ABOUT THE NETWORK

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

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

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

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

- Contracted Convenience Care Clinics are designated on our website when you log on to your account at HealthPartnersUnityPointHealth.com. You must use a designated Convenience Care Clinic to obtain the Convenience Care benefit shown in the Benefits Chart.
- Durable medical equipment and supplies must be obtained from or repaired by approved vendors
- All services for the purpose of weight loss must be provided by a designated Physician. Your Physician will obtain or verify prior authorization for these services with HealthPartners UnityPoint Health, as needed.
- For Specialty Drugs that are self-administered, you must obtain the Specialty Drugs from a designated vendor to be covered as Network Benefits. Coverage is described in the Benefits Chart

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

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 under state or federal law.

Conditions that qualify for this benefit are:

- Continuation of treatment for up to 90 days for Insureds undergoing active treatment for a chronic or acute medical condition (this includes behavioral health conditions)
- A specified course of treatment for a terminal Illness or a related condition, for a period of up to 90 days
- Pregnancy within the first trimester, for up to 90 days, pregnancy beyond the first trimester of pregnancy, with such care continuing through the postpartum care related to the childbirth and delivery

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.

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

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

PRIOR AUTHORIZATION FOR SERVICES

Your Physician may be required to obtain prior authorization for certain services. Your Physician will coordinate the authorization process for any services which must first be authorized. You may call the Member Services Department or log on to your account at HealthPartnersUnityPointHealth.com for a list of which services require your Physician to obtain prior authorization.

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

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

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

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

If the initial determination is made not to approve the service, we will notify your Health Care Provider and Hospital, if appropriate, by telephone within one working day of the determination, and we will send written verification with details of the denial. If you want to request an expedited review, or have received a denial of an authorization and want to appeal that decision, you have a right to do so. If your complaint is not resolved to your satisfaction in the internal complaint and appeal process, you may request an external review under certain circumstances. Refer to the information regarding Appeals Involving Medical Necessity Determinations under “Disputes and Complaints” for a description of how to proceed.

PREDETERMINATION OF PEDIATRIC DENTAL BENEFITS

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

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

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

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

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

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

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

Call Member Services for more information on predetermination of benefits.

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

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

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

ACCESS TO RECORDS AND CONFIDENTIALITY

We comply with the state and federal laws governing the confidentiality and use of protected health information and medical or dental records. When your Provider releases health information to us according to state law, we can use your protected health information when necessary, for certain health care operations, including: 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 required by another law. When you enrolled for coverage, you authorized our access to use your records as described in this paragraph, and this authorization remains in effect unless it is revoked.

DEFINITIONS

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

Authorized Representative. This is a person appointed by you to act on your behalf in connection with an initial claim, an appeal of an adverse benefit determination, or both. To designate an authorized representative, you must complete and sign our "Appointment of Authorized Representative" form and return it to us. You should specify on the form the extent of the authorized representative's authority. This form is available by logging on to your account at HealthPartnersUnityPointHealth.com.

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

Eligible Dependents. These are the persons shown below. Under this Certificate, a person who is considered an Enrollee is not qualified as an eligible dependent. A person who is no longer an eligible dependent (as defined below) on an Enrollee's Certificate may qualify for continuation of coverage within the group as provided in the "Continuation of Group Coverage" section of this Certificate.

1. **Spouse.** This is an Enrollee's current legal spouse. If both married spouses are covered as Enrollees under this Certificate, only one spouse shall be considered to have any Eligible Dependents.

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

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

3. **Full-time Student.** This is an Enrollee's Child as defined above, who is 26 years of age or older, unmarried, enrolled in and attending full-time a recognized course of study or training in a public or private secondary school, college, university, or licensed trade school, and is primarily dependent on the Enrollee for support and maintenance. The full-time student may continue coverage beyond age 26 on their existing Policy. The Child must have been on the Policy prior to turning age 26. If the Child is not enrolled during the initial enrollment period or qualifying event, the Child will be considered a late entrant and will have to wait until the next open enrollment period or another qualifying event to enroll.

   Full-time student status continues during: (a) regularly scheduled school vacation periods; or (b) absence from classes in which enrolled, due to physical or mental disability, until the end of the current term, quarter or semester, but in no event for more than four months (Note: this does not include absence from classes or termination of student status for personal reasons or pregnancy). In order to maintain full-time student status during regularly scheduled school vacation periods (see clause (a) above), the Dependent must meet the eligibility requirements as a full-time student immediately prior to and immediately after the vacation period. Full-time student status also continues if a Dependent is unable to carry a full course load due to Illness, Injury or physical or mental disability, so long as the course load is at least 60% of what otherwise is considered to be a full-time course load by the institution in question.

   As long as an unmarried, adult Child is a full-time student at an accredited post-secondary institution, there is no age limit or Iowa residency requirement, and the Child may remain on the parent's Policy until the Child's status changes. You are responsible for reporting eligibility changes for any Eligible Dependent on your Policy within the specified special enrollment time period. Coverage will end at the end of the month in which the Child gets married, ceases being a full-time student, ceases being a Dependent, or otherwise becomes ineligible. After a Child turns 26 and is enrolled but terminates coverage at a later time, the Child will not be able to return to the parent's policy.

4. **Student on medical leave or other change in enrollment.** This is a Full-time Student, as defined above, who, due to a Medically Necessary leave of absence or other change in enrollment, is not able to maintain Full-time Student status. A Student continues to be covered during the Medically Necessary leave of absence, provided that we receive documentation from the student's treating Physician which states that the Child is suffering from a serious Illness or Injury and that the leave of absence or other change in enrollment is Medically Necessary.

   Coverage for the student on medical leave will continue until the earlier of one year from the date that the Medically Necessary leave of absence (or other change in enrollment) occurs or the date coverage under the Plan otherwise terminates.

5. **Disabled Child.** This is an Enrollee's Dependent Child as defined above who is (a) incapable of self-sustaining employment by reason of intellectual disability, mental Illness or disorder, or physical disability; and (b) chiefly Dependent on the Enrollee for support and maintenance. The disability must have come into existence prior to attainment of the limiting age described above. The Enrollee must give us a written request for coverage of a disabled child. The request must include written proof of disability and must be approved by us, in writing. We must receive the request within 31 days of the date an already enrolled Dependent becomes eligible for coverage under this definition. We reserve the right to periodically review disability, provided that after the first two years, we will not review the disability more frequently than once every 12 months.

Enrollee. This is a person who is eligible through the Group Health Plan Sponsor's Group Policy, applies and is accepted by us for coverage under this Certificate.

Enrollment Date. This is the first day of coverage under this Certificate, or the first day of the Waiting Period, if earlier.

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

Group Health Plan Sponsor. This is the purchaser of this Certificate's group medical coverage, which covers the Enrollee and any Eligible Dependents.

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

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

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

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

Waiting Period. This is, for a potential Insured, the period that must pass before the Insured is eligible, under the Group Health Plan Sponsor's eligibility requirements, for coverage under this Certificate.

DISPUTES AND COMPLAINTS

DETERMINATION OF COVERAGE

Eligible services are covered only when Medically Necessary or Dentally Necessary for the proper treatment of an Insured. Our medical or dental directors, or their designees, make coverage determinations of Medical Necessity or Dental Necessity, restrictions on access and appropriateness of treatment, and they make final authorization for Covered Services. Coverage determinations are based on established Coverage Criteria Policies, which are subject to periodic review and modification by the medical or dental directors. Frequency limits, Deductibles, Copayments or Coinsurance, or other maximums or limits for certain covered Pediatric Dental services may not apply for certain medical conditions if you meet specific coverage criteria set by our dental directors. Covered Prescription Drugs are based on requirements established by our Pharmacy and Therapeutics Committee, and are subject to periodic review and modification.

COMPLAINTS

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

2. **Definitions:**

   Adverse Determination. This means a determination by a health carrier that an Admission, availability of care, continued stay, or other health care service, other than a dental care service, that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. Rescissions of coverage are also considered Adverse Determinations.

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

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

3. Complaint and Appeal Process

a. Complaints:

A complainant may submit a complaint to the Member Services Department either in writing or orally. A written complaint will be considered a first level appeal under the appeal process described below. The Member Services Department will make every effort to resolve the complaint. The Member Services Department will investigate the complaint and provide for informal discussions.

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

b. Appeals Process:

A complainant can seek further review of a complaint not resolved through the complaint process described above. HealthPartners UnityPoint Health offers a single level internal appeal process. If you are not satisfied with the outcome of your internal appeal, in certain circumstances you may be eligible to receive an external review of your claim performed by an Independent Review Organization (IRO) coordinated by the Iowa Insurance Division. The steps in these appeal processes are outlined below.

(1) Internal Appeal. You or your Authorized Representative must file your appeal within **180 days** of the Adverse Determination. 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 UnityPoint Health
Member Services Department
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 866-843-3461

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 appeal.

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

Pre-Service Appeals

If the appeal concerns urgent services, you or your Health Care Provider may request an expedited review either orally or in writing. Within 72 hours of such request, a decision on your appeal will be made. In the event that you have not provided all information necessary to make a decision, you will be notified of such failure within 24 hours. You will then be given 48 hours to provide the requested information. You will be notified of the benefit determination within 48 hours after the earlier of our receipt of the complete information or the end of the time granted to you to provide the specified additional information.

If the appeal concerns non-urgent services, a decision on your appeal will be made and communicated to you within 15 calendar days. Non-urgent time periods may be extended for up to 14 days if you agree. If we request an extension we will notify you in advance of the extension and the reasons for the extension.

Concurrent Care Appeals

If the appeal concerns urgent concurrent care 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 and communicated to you. In the event that you have not provided all information necessary to make a decision, you will be notified of such failure within 24 hours. You will then be given 48 hours to provide the requested information. You will be notified of the benefit determination within 48 hours after the earlier of our receipt of the complete information or the end of the time granted to you to provide the specified additional information.

If the appeal concerns non-urgent concurrent care services, a decision on your appeal will be made and communicated to you within 30 calendar days of receipt of your appeal request.

If you are appealing a reduction or termination of an ongoing course of treatment which has been previously approved by us, you will have continued coverage under your medical benefit pending the outcome of an internal appeal. This provision does not apply to requests for extension of the course of treatment beyond the already approved period or number.

Post-Service Appeals

A decision on your appeal will be made and communicated to you within 60 calendar days of receipt of your appeal request.

Adverse Benefit Determination (Denial) Notifications

All Adverse Determination notifications described above will comply with applicable law, will be provided in culturally and linguistically appropriate manner, and will address the following:

(a) Information sufficient to identify the claim involved (including date of service, Health Care Provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings);

(b) Specific reason(s) for the determination, including the denial code and corresponding meaning, as well as a description of our clinical criteria/standard that was used in denying the claim (including a discussion of the decision in final adverse benefit determinations);

(c) Descriptions of all internal appeal and external review processes;

(d) Information on how to initiate an appeal

(e) Information about the availability of, and contact information for, office of health insurance consumer advocate; and

(f) A statement that you are entitled to receive reasonable access to/copies of all documents, records, and other information relevant to the denied claim.

(2) External Appeal. If your request was denied after your internal appeal of a Medical Necessity determination, you have the right to request external review of our decision from the Iowa Insurance Division. See section 4. External Review Procedures below for a description of this process.

If your request was denied after the internal appeal of any other issue, you or your Authorized Representative may submit a complaint to:

Iowa Insurance Division's Market Regulation Bureau
1963 Bell Avenue
Suite 100
Des Moines, IA 50315
Telephone: 877-955-1212 or 515-654-6640
Fax: 515-654-6500
Website: iid.iowa.gov/insurance-consumer-complaint

4. External Review Procedures:

a. Eligibility for External Review. External review by an Independent Review Organization (IRO) through the Iowa Insurance Division is available to you at **no cost** if you experience a rescission of your coverage or the denied service is a covered benefit but was reduced, denied, or terminated for failing to meet clinical coverage criteria for:

- Medical necessity
- Appropriateness
- Health care setting
- Level of care
- Effectiveness
- The service or treatment is Experimental/Investigational

You are not eligible to request an external review for a claim that was denied because:

- The service is limited or not covered by the express language of this Certificate, or
- You went to an out-of-Network Provider.

You must exhaust the internal appeal process, as evidenced by a Final Adverse Determination letter, prior to requesting an External Review, except in the following cases:

- You did not receive a written decision for your internal pre-service appeal within 30 days of the date you filed it
- You did not receive a written decision for your internal post-service appeal within 60 days of the date you filed it
- We have waived our right to consider the internal appeal
- You have a medical condition for which the time frame for completion of an internal review or grievance would seriously jeopardize your life, health, or ability to regain maximum function (this qualifies you for an expedited external review)
- Your claim was denied as Experimental or Investigational, and your doctor certifies that the denied service or treatment would be significantly less effective if not promptly initiated (this qualifies you for an expedited external review)

b. Type of External Review. The great majority of external reviews are standard external reviews. This means the IRO has 45 days from the date the request is received to issue a decision.

For urgent situations, **expedited review** is available. In an expedited external review, the IRO issues a decision within 72 hours of receiving the request. Expedited external review is available only in the following circumstances:

- Your doctor certifies that exhausting internal appeals OR the standard 45 day external review would seriously jeopardize your life, health, or ability to regain maximum function
- Your claim was denied as Experimental or Investigational and your doctor certifies in writing that the service would be significantly less effective if not promptly initiated
- The final Adverse Determination concerns any one of the following in relation to emergency services, and you have not yet been discharged from the Facility:
    - An Admission
    - Availability of care
    - Continued stay
    - A health care service

c. Filing Deadline. You must file your request for an external review within **four months** from the date you received your final adverse benefit determination letter.

d. Supporting Documents, Forms and Authorized Representatives. You do not need to resend the records and materials that you included with your internal appeal, because we are required to send everything we considered in making the final Adverse Determination to the IRO. However, you may submit any new or additional records and medical Provider letters if you wish. The type of information that will be helpful will depend on why your claim was denied. Allow yourself several weeks if you need to request medical records from a doctor or Hospital because it will take time for them to process your request.

You can obtain a copy of the External Review form by visiting the website or calling the Iowa Insurance Division, at the contact information listed below. There is a section on the External Review form for appointing an Authorized Representative, should you wish to do so. Be aware that once you appoint an Authorized Representative, that person will get all correspondence related to the External Review and you will not.

Iowa Insurance Division's Market Regulation Bureau
1963 Bell Avenue
Suite 100
Des Moines, IA 50315
Telephone: 877-955-1212 or 515-654-6640
Fax: 515-654-6500
Website: iid.iowa.gov
Email: iid.marketregulation@iid.iowa.gov

e. Submission of the External Review Form and Next Steps. The External Review form will instruct you where to send the completed form. Do not send any medical records, medical Provider letters, or other supporting documents along with the completed form. If your request for an External Review is approved you will be given an opportunity to submit these materials.

After you submit a completed external review form to the Iowa Insurance Division, the following events and time limits apply:

- Within **1 business da**y after getting your request, the Iowa Insurance Division sends a copy to us
- Within **5 business days** after we get your request, we are required to review it and determine if you are eligible for external review
- Within **1 business day** after this, we must notify the Iowa Insurance Division and you (or your Authorized Representative) in writing whether your request is complete and eligible
- The Iowa Insurance Division will then determine if you are eligible for an external review.
- Within **1 business day** after deciding you are eligible, the Iowa Insurance Division will assign an IRO to your claim, and notify you or your representative in writing of the IRO's contact information.

f. Submission of New Supporting Documentation. Once the IRO is selected, you have only **5 business days** to send the IRO any new supporting documentation. Email or fax your information to the IRO so they receive it as soon as possible or if necessary, send it via certified mail with signature confirmation.

The IRO Decision. The IRO will assign a medical reviewer who is a Physician with a background in the area of your prescribed treatment. The Physician will consider all the information submitted by all parties to the action. The IRO is not bound by any decision or conclusions we have made during the internal appeal process. The IRO will send the Iowa Insurance Division, us, and you (or your Authorized Representative) written notice of its decision within 45 days of receiving your request for an external review (or 72 hours in the case of an expedited external review). If the IRO's decision was given orally, the IRO must provide written notice of the decision within 48 hours of the oral notification. This decision must explain the reasoning for the decision and reference all evidence and evidence based standards in reaching the decision. If the IRO decides we must cover the claim, its decision is binding on us, and we must cover the service immediately after getting the IRO's decision and continue to pay for it.

CONDITIONS

RIGHTS OF REIMBURSEMENT AND SUBROGATION

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

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

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

COORDINATION OF THIS CERTIFICATE'S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payment from all Plans does not exceed 100% of the total Allowable Expense.

DEFINITIONS

1. **A Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

    a. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether Insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

    b. Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident-type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

    Each contract for coverage under a. or b. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

2. **This Plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

3. **Primary Plan/Secondary Plan.** The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.

   When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

4. **Allowable Expense** is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

   The following are examples of expenses that are not Allowable Expenses:

   a. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private Hospital room expenses.

   b. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

   c. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   d. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and by another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

   e. The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of Admissions, and preferred Provider arrangements.

   f. If a Plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expenses incurred that may not be subject to the deductible as described in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

5. **Closed Panel Plan** is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

6. **Custodial Parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.

2. a. Except as provided in Paragraph b., a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

   b. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide Out-of-Network Benefits.

3. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

4. Each Plan determines its order of benefits using the first of the following rules that apply:

   a. Non-Dependent or Dependent. The Plan that covers the person other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a Dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

   b. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one Plan the order of benefits is determined as follows:

      (1) For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:

         - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
         - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

      (2) For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:

         (a) If a court decree states that one of the parents is responsible for the Dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

         (b) If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;

         (c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of Subparagraph (1) above shall determine the order of benefits; or

         (d) If there is no court decree allocating responsibility for the Dependent Child's health care expenses or health care coverage, the order of benefits for the Child are as follows:

            - The Plan covering the Custodial Parent;
            - The Plan covering the Spouse of the Custodial Parent;
            - The Plan covering the Non-Custodial Parent; and then
            - The Plan covering the Spouse of the Non-Custodial Parent.

      (3) For a Dependent Child covered under more than one Plan of individuals who are the parents of the Child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the Child.

   c. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a. can determine the order of benefits.

   d. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a. can determine the order of benefits.

e. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

f. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

1. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
2. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed Panel Plan; COB shall not apply between that Plan and other Closed Panel Plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. HealthPartners UnityPoint Health may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. HealthPartners UnityPoint Health need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give HealthPartners UnityPoint Health any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, HealthPartners UnityPoint Health may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. HealthPartners UnityPoint Health 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 the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by HealthPartners UnityPoint Health is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION OF BENEFITS

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance Certificate, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the "primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim. Any plan that does not contain your state's COB rules will always be primary.

When This Plan Is Primary

If you or a family member are covered under another plan in addition to this one, we will be primary when:

Your Own Expenses

- The claim is for your own health care expenses, unless you are enrolled in Medicare and both you and your Spouse are retired.

Your Spouse's Expenses

- The claim is for your Spouse, who is enrolled in Medicare, and you are not both retired.

Your Child's Expenses

- The claim is for the health care expenses of your Child who is covered by this plan and
- You are married and your birthday is earlier in the year than your Spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule"; or
- You are separated or divorced and you have informed us of a court decree that makes you responsible for the Child's health care expenses; or
- There is no court decree, but you have custody of the Child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits in accordance with the terms of your Certificate, just as if you had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary

We will be secondary whenever the rules do not require us to be primary.

How We Pay Claims When We Are Secondary

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An "allowable expense" is a health care expense covered by one of the plans, including Copayments, Coinsurance and Deductibles.

- If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) usually have contracts with their Providers.
- We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We may reduce our payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid do not exceed the total allowable expense for your claim. We will credit any amount we would have paid in the absence of your other health care coverage toward our own plan Deductible.
- If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.
- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain precertification, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

MEDICARE AND THIS CERTIFICATE

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

Medicare is the primary payer for persons with end stage renal disease, after the 30 month period following the earlier of (1) the month in which the Insured begins a regular course of renal dialysis, or (2) the first of the month in which the Insured became entitled to Medicare, if the Insured 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 Insureds 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 Insured or their Spouse or parent has group health plan coverage due to current employment, or (2) the Insured or their Spouse or parent has coverage not due to current employment, regardless of the number of employees of the employer.

Medicare is secondary payer for Medicare Enrollees who: (1) are active employees and (2) are covered by Medicare because they have reached age 65 when there are 20 or more employees in the group. The Medicare secondary payer rules change from time to time and the most recent rule will be applied.

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

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

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

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

EFFECTIVE DATE AND ELIGIBILITY

EFFECTIVE DATE

Your coverage begins on the date contained in the information which accompanies your initial identification card (Effective Date). Your coverage is contingent upon fulfillment of the eligibility rules contained in the Group Policy.

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

ELIGIBILITY

You must make written application to enroll yourself and any Eligible Dependents, and such application must be received by us within 31 days of the date you first become eligible, except as specified below for newborn and newly adopted Children. Similarly, you must make written application to enroll a newly acquired Dependent, and we must receive such written application and receive any required payments, if any, within 31 days of when you first acquire the Dependent (e.g., through marriage), in order for coverage under this Certificate to be effective on the date specified under "Special Enrollment Period".

LATE ENROLLMENT

If you do not enroll yourself or any Eligible Dependents within 31 days of the date that you or your Dependents first become eligible, you may enroll yourself and any Eligible Dependents during the annual open enrollment period or a special enrollment period.

SPECIAL ENROLLMENT PERIOD

1. If you are eligible, but not enrolled for coverage under this Certificate, or your Dependent, if the Dependent is eligible but not enrolled for coverage under this Certificate, you or your Dependent may enroll for coverage under the terms of this Certificate if all of the following conditions are met:

    a. you or your Dependent were covered under a group health plan or had health insurance coverage at the time coverage was previously offered to you or your Dependent;

    b. you stated in writing at the time of initial eligibility that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the Group Health Plan Sponsor required this and provided you with notice of this requirement and the consequences of it;

    c. you or your Dependent's coverage described in a. above was:

        (1) under a COBRA continuation provision and that coverage was exhausted; or

        (2) not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, cessation of Dependent status or reduction in the number of hours of employment; a situation in which the individual incurs a claim that would meet or exceed a lifetime limit on all benefits; a situation in which coverage is no longer offered to the class of similarly situated individuals that includes the individual; a situation in which an individual loses coverage through a health maintenance organization or other arrangement because that individual no longer resides, lives or works in the health maintenance organization's service area or a situation in which the individual's benefit option is terminated) or the employer contributions toward coverage were terminated; and

    d. you requested this enrollment not later than 30 days after the date of exhaustion of coverage described in c. (1) above, or one of the events listed in c. (2) above.

2. Dependents may enroll if: (a) a group health plan makes coverage available with respect to your Dependent; (b) you are covered under this Certificate (or have met any Waiting Period applicable to becoming covered under this Certificate and are eligible to be enrolled under this Certificate but for a failure to enroll during a previous enrollment period); and (c) a person becomes your Dependent through marriage, birth, or adoption or placement for adoption. This Certificate shall provide for a Dependent special enrollment period during which the person may be enrolled under this Certificate as your Dependent and in the case of the birth or adoption of a Child, your Spouse may be enrolled as your Dependent if otherwise eligible for coverage. You may also enroll at this time. A Dependent special enrollment period shall be a period of not less than 30 days and shall begin on the later of:

a. the date Dependent coverage is made available; or

b. the date of the marriage, birth, or adoption or placement for adoption described in (c) in the paragraph above.

If an Enrollee seeks to enroll a Dependent during the first 30 days of a Dependent special enrollment period, the coverage of the Dependent shall become effective:

a. in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

b. in the case of a Dependent's birth, as of the date of birth;

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

d. in the case of a Child support order or other court order; as of the date specified in the order.

3. You may also enroll yourself and any Eligible Dependents if you enroll within 30 days of any of the events under this item 3.:

a. If you or your Dependents lose group coverage because of termination of employment (except for gross misconduct) or reduction in hours.

b. If you or your Dependents lose group coverage because of the death of the Enrollee.

c. If you or your Dependents lose group coverage because of divorce or legal separation.

d. If your Dependent loses group coverage because of loss of eligibility as a Dependent Child.

e. If you or your Dependents lose group coverage because the group Enrollee's initial enrollment for Medicare.

f. For a retired Enrollee, Spouse and other Dependents, if you lose group coverage because of the bankruptcy filing by a former employer, under Title XI, United States Code, on or after July 1, 1986.

SPECIAL RULES RELATING TO MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM ("CHIP")

In general, if you are eligible but not enrolled for coverage under the terms of this plan (or if your Dependent is eligible but not enrolled for coverage under such terms), you may enroll for coverage under the terms of this plan if either of the following conditions is met:

- **Termination of Medicaid or CHIP Coverage.** You or your Dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a state Child health plan under title XXI of such Act and coverage of you or your Dependent under such plan is terminated as a result of loss of eligibility for such coverage and you request coverage under this plan not later than 60 days after the date you or your Dependent lose coverage under that plan; or
- **Eligibility for Employment Assistance under Medicaid or CHIP.** You or your Dependent becomes eligible for assistance, with respect to coverage under this plan, under such Medicaid plan or state Child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if you request coverage under this plan not later than 60 days after the date you or your Dependent becomes eligible for such assistance.

ENROLLMENT OF NEWBORN OR NEWLY ADOPTED CHILDREN

Newborn infants and newly adopted Children will be covered if enrolled within 60 days of their date of birth or placement for adoption and you make the required premium payment. If you enroll newborn infants or newly adopted Children more than 60 days after their eligibility date, they will be considered Late Entrants.

CHANGES IN COVERAGE

Any change in coverage is subject to our approval. If a change in coverage is requested by us or the Group Health Plan Sponsor, it is effective on the date mutually agreed to by the Group Health Plan Sponsor and us, unless the provision pertaining to that change specifically provides otherwise.

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

CONTINUATION OF GROUP COVERAGE

If your eligibility for group coverage under this Certificate ends because of one of the events shown below, called "qualifying events," you may be eligible to continue group coverage. Each of these options is shown below.

1. Qualifying Events.

Coverage under this Certificate may be continued by an Enrollee, Spouse and other Dependents, enrolled at the time coverage would otherwise end, or a Child born to or placed for adoption with the Enrollee during the period of continuation coverage, as a result of one of the following qualifying events.

a. Termination of employment (except for gross misconduct) of the Enrollee, or reduction in hours resulting in a loss of group coverage.

b. Death of the Enrollee.

c. Divorce or legal separation from the Enrollee.

d. Loss of eligibility as a Dependent Child.

e. Initial enrollment of the Enrollee for benefits under Title XVIII of the Social Security Act (Medicare).

f. For a retired Enrollee, Spouse and other Dependents, the bankruptcy filing by a former employer, under Title XI, United States Code, on or after July 1, 1986.

2. Duration of Continuation Coverage.

The maximum period coverage can be continued depends on the qualifying event. It may be terminated earlier as shown below. The maximum period of continuation coverage starts on the day of the qualifying event.

a. **Maximum period.**

(1) Termination and reduced hours. The maximum period of continuation coverage is 18 months. If a second qualifying event, other than the employer's bankruptcy, occurs during the 18 months, the maximum period of continuation coverage is 36 months. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".

(2) Disabled Enrollee, Spouse or Dependent Child. If the Enrollee, Spouse or other Dependent is disabled under Title II or XVI of the Social Security Act, at any time during the first 60 days of continuation coverage, the 18-month maximum continuation period may be extended to 29 months. The disabled person must notify the Group Health Plan Sponsor within 60 days of the date of determination of disability, and within the initial 18-month continuation period. If a second qualifying event (other than bankruptcy) occurs during the extended 29-month period, the maximum period of continuation coverage is 36 months.

(3) Bankruptcy. In the case of bankruptcy of a retired Enrollee's former employer, the maximum period of continuation coverage is until the death of the retired Enrollee. In the case of the surviving Spouse or Dependent Children of the retired Enrollee, the maximum period of continuation coverage is 36 months after the death of the retired Enrollee.

(4) Divorce or legal separation. The maximum period of continuation coverage is 36 months. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".

(5) Death of Enrollee. The maximum period of continuation coverage is 36 months. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".

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

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

(1) End of the plan. The Group Health Plan Sponsor terminates the agreement under which this coverage is offered to its Enrollees.

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

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

(4) Termination of extended coverage for disability. In case a person receives extended (29-month) continuation coverage due to disability at the time of termination or reduced hours, the extended coverage terminates at the beginning of the month 30 days after a final determination that the person is no longer disabled.

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

3. Election of Continuation Coverage.

a. You have 60 days to elect continuation of group coverage. The 60-day period begins on the date your group coverage would otherwise terminate due to a qualifying event or the date on which written notice of your right of continued group coverage is mailed, whichever is later.

b. If you wish to continue group coverage as shown above, you must apply in writing to your Group Health Plan Sponsor (not us). You must also pay your first monthly payment within 45 days of the date you elected to continue group coverage. Thereafter, your monthly payments are due and payable at the beginning of each month for which coverage is to be continued.

c. You or your enrolled Dependents must notify the Group Health Plan Sponsor within 60 days, when divorce, legal separation, change in status resulting in a loss of eligibility as a Dependent would end coverage or a second qualifying event occurs. The 60 day period begins on the date of the divorce, legal separation, change in Dependent status or second qualifying event.

d. You may be required to pay the entire cost of COBRA continuation coverage plus a 2% administrative fee for each Enrollee and enrolled Dependent.

4. Procedures for Providing Notices Required under this "Continuation of Group Coverage" section.

a. You must comply with the time limits for providing notices required in paragraph 3.c. above.

b. Your notice must be in writing and contain at least the following information:

(1) The name(s) of the Enrollee, covered Spouse and other covered Dependents;

(2) The qualifying event or disability; and

(3) The date on which the qualifying event (if any) occurred.

c. You must check with your employer for information regarding the person or entity that your notice should be sent to.

We will comply with applicable federal law for a covered employee that is called to active military duty in the uniformed services.

REPLACEMENT OF COVERAGE WHEN YOU ARE CONFINED

When the Group Health Plan Sponsor replaces the Group Policy with that of another health plan offering similar benefits, coverage will be extended if you are confined in an institution for medical care or treatment that would otherwise be covered under this Certificate. Coverage will be extended only for services related to the confinement and incurred prior to the date that coverage ends or services billed with the Facility charges. Coverage for these services will end on the earlier of the date of discharge or the date benefits provided under this Certificate are exhausted.

TERMINATION

An Insured's coverage under this Certificate terminates, when any of the following events occur.

1. The premium payment is due on or before the beginning of the month during which coverage is provided. There is a 31-day grace period during which to pay the required payment. Coverage under this Certificate will continue in effect during the grace period. If no payment is received by us within the 31-day grace period, coverage terminates, retroactive to the paid through date. We are not obligated to accept any payment after the end of the grace period.
2. When an Enrollee ceases to be eligible under the terms of the Group Policy, coverage for the Enrollee and all enrolled Dependents terminates on the last day of the month in which the Enrollee's eligibility ceases, unless group continuation is elected as described in "Continuation of Group Coverage" above.
3. When an enrolled Dependent reaches the limiting age and no longer meets this Certificate's definition of Eligible Dependent, coverage for that Dependent terminates on the last day of the month in which the Dependent reaches the limiting age, unless group continuation is elected as described in the section above titled, "Continuation of Group Coverage".
4. When any other enrolled Dependent no longer meets this Certificate's definition of Eligible Dependent, coverage for that Dependent terminates on the last day of the month in which the Dependent's eligibility ceases, unless group continuation is elected as described in "Continuation of Group Coverage" above.
5. When the Certificate maximum eligibility period under the group continuation coverage described in "Continuation of Group Coverage" above expires for an Enrollee or Dependent.
6. When the Group Policy is terminated, either as requested by us or the Group Health Plan Sponsor, in accordance with the terms of the Group Policy.
7. When the Group Health Plan Sponsor terminates participation under the Group Policy.
8. In the event of misstatements made by the applicant in the application for coverage under this plan, no misstatement, except fraudulent misstatements, shall be used to void this Certificate or deny a claim for benefits covered under this Certificate for loss incurred or disability commencing after the expiration of the two year period beginning from the issue date of this Certificate.

To the extent that a termination would be considered a rescission (a cancellation or discontinuance of coverage under a health plan that has a retroactive effect) under federal law under items 2., 3., 4., 5. and 8. above, the Group Health Plan Sponsor is required to give the Insured 30 days advance notice of termination.

CLAIMS PROVISIONS

Notice of Claims. If you receive services from a Network Provider, the Provider will submit a claim to us for you. If you receive services from an Out-of-Network Provider, you must submit a claim to us. You can get a claim form on our website at HealthPartnersUnityPointHealth.com or by calling Member Services. Send us your claim form with an itemized list of the services provided on the Provider's stationery as outlined under "Proof of Loss" below, including the following information:

- Identification of Provider: full name, address, tax or license ID numbers, and Provider numbers
- Patient information: first and last name, date of birth, gender, relationship to plan member, and daytime phone number
- Date(s) of service
- Charge for each service
- Place of service (office, Hospital, etc.)
- For Injury or Illness: date and diagnosis
- For Inpatient claims: Admission date, patient status, attending Physician ID
- Days or units of service
- Revenue, diagnosis, and procedure codes
- Description of each service

Send any claims to:

HealthPartners UnityPoint Health
8170 33rd Avenue South
P.O. Box 1289
Minneapolis, MN 55440-1289

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. Any bill received after 90 days from the date of service can be denied even if it is for a Covered Service, unless you were unable to submit the bill because you were legally incompetent.

Time of Payment of Claims. We will make payment promptly upon receipt of due written proof of loss. Benefits which are payable periodically during a period of continuing loss shall be payable on at least a monthly basis. We will notify you of our benefit determination if you have any remaining liability within 30 days of receipt of a completed claim. This time period may be extended by us for an additional 15 days for circumstances beyond our control.

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

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

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

STATEMENT OF ERISA RIGHTS

For group health plans that are subject to ERISA, federal law and regulations require that this “Statement of ERISA Rights” be included in this Group Certificate. This “Statement of ERISA Rights” is not applicable to group health plans that are not subject to ERISA. Your Group Health Plan Sponsor can tell you whether or not your plan is subject to ERISA. ERISA rights are in addition to any rights you may also have under state law; however, federal law may not invalidate, impair or supersede state law.

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and where applicable, copies of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security 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 the section “Continuation of Group Coverage” in this Group Certificate.

Prudent actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance With Your Questions

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

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 Certificate's benefits: HealthPartners UnityPoint Health For all other matters: your employer.
Named Fiduciary:	For this Group Certificate's benefits: HealthPartners UnityPoint Health For all other matters: your employer.
Funding:	This Group Certificate is fully Insured under Iowa law.
Network Providers:	HealthPartners UnityPoint Health 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.
Contact for Continuation of Coverage Notices:	See your employer's plan documents.