



## Summary Plan Description

---

*St. Paul Public Schools  
Empower HRA NationalONE<sup>SM</sup> Plan*



**TABLE OF CONTENTS**

<b>Section</b>	<b>Page</b>
<b>Health Reimbursement Account (HRA)</b> .....	<b>2</b>
<b>Specific Information About the Plan</b> .....	<b>3</b>
<b>About HealthPartners and Your Employer</b> .....	<b>4</b>
<b>Responsibilities of Covered Persons</b> .....	<b>5</b>
<b>Rights Upon Termination or Amendment of the Plan</b> .....	<b>5</b>
<b>I. Introduction to the Summary Plan Description</b> .....	<b>5</b>
A. Summary Plan Description (SPD) .....	5
B. Medical Administrative Services Agreement (ASA) .....	5
C. Conflict With Existing Law .....	5
D. Access to Records and Confidentiality .....	6
<b>II. Description of Eligible Expenses</b> .....	<b>7</b>
<b>III. Coordination of Benefits</b> .....	<b>7</b>
<b>IV. Continuation of Group Coverage</b> .....	<b>7</b>
<b>V. Claims Procedures</b> .....	<b>9</b>

This Summary Plan Description (SPD) describes an Employer funded health reimbursement account (HRA), which is available to you as part of the Empower HRA NationalONE<sup>SM</sup> Plan. The HRA and the medical benefit plan are together referred to as “the Plan”.

In the event of a conflict between this SPD and your Group Certificate, the SPD governs the HRA portion of the Plan and the Group Certificate governs the medical benefits portion of the Plan.

“Group Certificate” is the evidence of coverage for persons covered under the medical benefit plan.

**Summary Plan Description Effective Date: The later of January 1, 2012 and the Covered Person's effective date of coverage under the Plan.**

## **Health Reimbursement Account (HRA)**

Your Employer has established a HRA (a notional bookkeeping account) for you. Your Employer funds a specified amount to your HRA to be used for Eligible Expenses (as outlined in this SPD).

The HRA along with your medical benefit plan are a single employer plan. However, only the HRA portion of the Plan is described in this SPD.

### **Employer Funding**

<b>Single</b>	\$500
<b>Single + One Dependent</b>	\$750
<b>Family</b>	\$1,000

### **Funding For Mid Year Hires**

*If coverage is effective after the beginning of the Plan Year, Employer funding will be prorated on a monthly basis.*

*Regardless of effective date of coverage, Employer funding will be made in full for the applicable month.*

### **HRA Rollover**

*Any unused funds remaining in your account 3 months after the end of the plan year will roll over each year for future medical expenses. The rollover amount will not be determined until 3 months after the end of the plan year. These funds are not available for your use until after the rollover has occurred.*

## SPECIFIC INFORMATION ABOUT THE PLAN

<b>Employer:</b>	St. Paul Public Schools
<b>Name of the Plan:</b>	The Plan shall be known as the St. Paul Public Schools Empower HRA National <i>ONE</i> <sup>SM</sup> Plan, which provides employee and dependent medical benefits and a health reimbursement account (HRA).
<b>Address of the Plan:</b>	360 Colborne Street St. Paul, MN 55102 651-767-8227
<b>Group Number:</b>	3101/3000
<b>Plan Year:</b>	The period beginning on each January 1 in which the provisions of the Plan are in effect.
<b>Plan Fiscal Year Ends:</b>	December 31
<b>Plan Sponsor:</b> (is ultimately responsible for the management of the Plan; may employ or contract with persons or firms to perform day-to-day functions such as processing claims and performing other Plan-connected services.)	St. Paul Public Schools
<b>Agent for Service of Legal Process:</b>	General Counsel for St. Paul Public Schools
<b>Named Fiduciary:</b> (has the authority to control and manage the operation and administration of the Plan; has discretionary authority to determine eligibility for benefits or to construe the terms of the Plan.)	For purposes of determining eligibility and enrollment, and for funding claims paid and all related activities and responsibilities under the Plan, St. Paul Public Schools is the named fiduciary.  HealthPartners Administrators, Inc. has final discretionary authority solely for purposes of determining coverage of claims and appeals.
<b>Funding:</b>	Claims under the Plan are paid from the general assets of the Employer.
<b>Plan Manager:</b> (provides administrative services to the Plan Sponsor in connection with the operation of the Plan, such as processing of claims and other functions, as may be delegated to it.)	HealthPartners Administrators, Inc. 8170 33 <sup>rd</sup> Avenue South P.O. Box 1309 Minneapolis, MN 55440-1309 (952) 883-6000
<b>Network Providers:</b>	National <i>ONE</i> <sup>SM</sup> Network
<b>Contributions:</b>	Please refer to the most recent enrollment material for information regarding contributions to your Plan which is hereby incorporated by this reference.

## HEALTHPARTNERS MISSION

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

### ABOUT HEALTHPARTNERS and YOUR EMPLOYER

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

**Employer ("Plan Sponsor").** The Employer has established the Plan to provide medical benefits and a HRA for covered employees and their covered dependents ("Covered Persons"). The HRA is "self-insured" which means that the Plan Sponsor funds the HRA with its own assets. The HRA is described in the SPD. The Plan Sponsor has contracted with HPAI to provide administrative services for the HRA portion of the Plan. However, the Plan Sponsor is solely responsible for funding your HRA. The medical benefits plan is described in your Group Certificate, and is underwritten by HealthPartners Insurance Company.

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

The Plan Sponsor, by action of an authorized officer or committee, reserves the right to change, end or amend the Plan. The Plan Sponsor's decision to change the Plan may be due to changes in applicable laws or for any other reason. The Plan may be changed to transfer the Plan's liabilities to another plan or split the Plan into two or more parts.

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

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

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

## **RESPONSIBILITIES OF COVERED PERSONS**

1. Read this SPD and the enrollment materials completely and comply with the stated rules and limitations.
2. Contact providers to arrange for necessary medical appointments.
3. Pay any applicable copayments, deductibles and contributions as stated in this SPD.
4. Identify yourself as a Covered Person by presenting your identification card whenever you receive covered services under the Plan.

## **RIGHTS UPON TERMINATION OR AMENDMENT OF THE PLAN**

For a summary of Plan provisions governing benefits, rights and obligations of participants and beneficiaries under the Plan on termination of the Plan or amendment or elimination of benefit under the Plan, please consult your Employer.

### **I. INTRODUCTION TO THE SUMMARY PLAN DESCRIPTION**

#### **A. SUMMARY PLAN DESCRIPTION ("SPD")**

This SPD describes your HRA benefits. Your Group Certificate describes your medical benefit plan. This SPD should be read completely and in conjunction with your Group Certificate. Many of the provisions of both documents are interrelated; reading just one or two provisions may give you incomplete information regarding your rights and responsibilities. Many of the terms used in this SPD or the Group Certificate have special meanings and are specifically defined in the documents. Your documents should be kept in a safe place for your future reference.

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

#### **B. MEDICAL ADMINISTRATIVE SERVICES AGREEMENT ("ASA")**

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

#### **C. CONFLICT WITH EXISTING LAW**

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



## D. ACCESS TO RECORDS AND CONFIDENTIALITY

The Plan Sponsor complies with applicable State and Federal laws governing the confidentiality and use of protected health information and medical records. As part of this Summary Plan Description, the Plan Sponsor is authorized to have access to and use protected health information held by any health care provider who delivers health care services to you under this Summary Plan Description. The Plan Sponsor is also allowed to use your protected health information when necessary, for: certain health care operations including, but not limited to: claims processing, including claims made for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, case management; care coordination and utilization management, disease management, underwriting, premium rating, claims experience reporting, the evaluation of potential or actual claims against the Plan Sponsor, auditing and legal services, and other access and use without further authorization if permitted or required by another law.

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

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

Certain limited information of all family members enrolled in the Plan will be viewable on the HRA account website by the enrolled employee. By enrolling in the Empower HRA NationalONE<sup>SM</sup> Plan you are acknowledging that you and all dependents enrolled in the Plan, understand that you, as the enrolled employee, will have access to limited information about all the claims submitted to your HRA account for reimbursement.

## II. DESCRIPTION OF ELIGIBLE EXPENSES

Eligible expenses are expenses incurred by you or your covered dependents that satisfy all of the conditions described in your Group Certificate up to the annual specified dollar amount available to you in your HRA.

The funds in your HRA are used to pay for Eligible Expenses. After you have used your HRA funds, you must pay any member liability due under the Plan.

## III. COORDINATION OF BENEFITS

In the event you also have health plan coverage with another source (i.e. as a dependent on a spouse's coverage), please notify HealthPartners Members Services at (952) 883-7000 or 1-866-443-9352 toll-free for instructions on coordinating benefits between plans. For hearing-impaired individuals, call (952) 883-5127 (TDD) or toll-free at 1-888-850-4762 (TDD). When claim payments are coordinated and adjusted between two health plans there are situations when a reimbursement from the HRA would be inappropriate.

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

**For purposes of Coordination of Benefits, the HRA portion of this Plan is always secondary to medical coverage under a non-Medicare plan.**

## IV. CONTINUATION OF GROUP COVERAGE

**For continuation provisions applicable to the medical benefit portion of your Plan, you will need to refer to your Group Certificate.**

Although your coverage under your Group Certificate along with your HRA is considered a single Employer plan, you may elect to continue your coverage under either:

- Both medical benefits under the Group Certificate and the HRA described in this SPD; or
- Only the medical benefits under the Group Certificate.

As required by the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), if your eligibility for group coverage under the HRA portion of the Plan ends because of qualifying events, you may be eligible to continue group coverage as shown below.

1. **Qualifying Events.** Coverage under the HRA portion of the Plan may be continued by a covered employee, covered dependent spouse and other covered dependents, enrolled at the time coverage would otherwise end, or a child born to or placed for adoption with the covered employee 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 covered employee, or reduction in hours resulting in a loss of group coverage.
  - b. Death of the covered employee.
  - c. Divorce or legal separation of the covered employee.
  - d. Loss of eligibility as a covered dependent child.
  - e. Initial enrollment of the covered employee for Medicare.
  - f. For a retired covered employee, spouse and other dependents, the bankruptcy filing by a former Employer, under Title XI, United States Code, on or after July 1, 1986.

2. **Duration of Continuation Coverage.** The maximum period coverage can be continued depends on the qualifying event. Continuation coverage may be terminated earlier as shown below. The maximum period of continuation coverage starts on the day of the qualifying event.

a. **Maximum period**

- (1) Termination and reduced hours. The maximum period of continuation coverage is 18 months. If a second qualifying event, other than the Employer's bankruptcy, occurs during the 18 months, the maximum period of continuation coverage is 36 months.
- (2) Disabled covered employee, covered dependent spouse or covered dependent child. If the covered employee, covered dependent spouse or other covered dependent is disabled under Title II or XVI of the Social Security Act, at the time of the termination of employment, or reduced hours of the covered employee, or within the first 60 days of continuation of coverage, the 18-month maximum continuation period may be extended to 29 months. The disabled person must notify the Plan Sponsor within 60 days of the date of determination of disability, and within the initial 18-month continuation period. If a second qualifying event (other than bankruptcy) occurs during the extended 29-month period, the maximum period of continuation coverage is 36 months.
- (3) Bankruptcy. In the case of bankruptcy of a retired covered employee's former Employer, the maximum period of continuation coverage is until the death of the retired covered employee. In the case of the surviving spouse or dependent children of the retired covered employee, the maximum period of continuation coverage is 36 months after the death of the retired covered employee.
- (4) Divorce or legal separation. The maximum period of coverage for a former spouse or dependents who lose coverage due to divorce or legal separation is 36 months.
- (5) Death of covered employee. The maximum period of coverage for a covered dependent surviving spouse and covered dependents who lose coverage due to the death of the covered employee is 36 months.
- (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 HRA portion of the Plan. The HRA portion of the Plan under which this coverage is offered to covered employees is terminated.
- (2) Failure to pay premium. The person receiving continuation coverage does not make the monthly payment within 30 days of the due date.
- (3) Other group health coverage. The person receiving continuation coverage becomes covered under any other group health type coverage, not containing an exclusion or limitation for any pre-existing condition of the person. If the other group health coverage contains a pre-existing condition limitation, continuation coverage is extended until the pre-existing limitation is satisfied or coverage is otherwise terminated. A person will not be subject to earlier termination of continuation coverage on account of coverage under another group plan that existed prior to that person's first day of continuation coverage.
- (4) Termination of extended coverage for disability. In case a person receives extended (29-month) continuation coverage due to disability at the time of termination or reduced hours, the extended coverage terminates at the beginning of the month 30 days after a final determination that the person is no longer disabled.
- (5) Termination provisions of the Plan.
- (6) Enrollment under Medicare. The person receiving continuation coverage becomes entitled to and covered under Medicare Part A or B coverage. A person will not be subject to earlier termination of continuation coverage on account of coverage under Medicare that existed prior to that person's first day of continuation coverage.

### 3. Election of Continuation Coverage

- a. You have 60 days to elect continuation of group coverage. The 60-day period begins on the date your group coverage would otherwise terminate due to a qualifying event or the date on which written notice of your right of continued group coverage is mailed, whichever is later.
- b. If you wish to continue group coverage as shown above, you must apply in writing to your Employer (not the Plan). You must also pay your first monthly payment within 45 days of the date you elected to continue group coverage. Thereafter, your monthly payments are due and payable at the beginning of each month for which coverage is to be continued.
- c. You or your covered dependents must notify the Plan Sponsor within 60 days, when divorce, legal separation, a change in status resulting in a loss of eligibility as a dependent would end coverage or a second qualifying event occurs. The 60 day period begins on the date of the divorce, legal separation, change in dependent status or second qualifying event.

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

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

St. Paul Public Schools  
360 Colborne Street  
St. Paul, MN 55102

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

## V. CLAIMS PROCEDURES

### A. HRA CLAIM PAYMENT

**Expenses submitted more than 3 months after the end of the plan year for that plan year's expenses will not be eligible for reimbursement under your HRA.**

**Automatic Claims Submission.** After your claim is processed for payment under the medical portion of the plan, any Eligible Expenses will be sent automatically to your HRA for payment consideration. After your claim is processed for payment under your HRA account any Eligible Expenses will be sent automatically to your FSA for payment consideration. Claims are paid based on the amount initially submitted. If the amount of the original claim later changes you must notify HealthPartners so that the claim can be adjusted.

You may opt out of automatic claims submission at any time if you do not wish for claims from the medical portion of the plan to be automatically submitted to your HRA for reimbursement.

**You MUST opt out of automatic claims submission if either of the following is true:**

**You have dual health plan coverage through a spouse.** In these instances reimbursement out of the HRA would not be appropriate if the claim may be paid by another source.

**You have a dependent covered under your health plan who does not qualify as a dependent under the Internal Revenue Code Section 152.** Reimbursement out of the HRA for dependents who meet the definition of dependent under the health plan, but not IRC Code section 152 are not allowable.

**Automatic Claims Submission Forms are available on-line at [www.healthpartners.com](http://www.healthpartners.com) or by calling Member Services.**

If you opt out of the automatic claim submission to your HRA, you must submit a manual claim for your Eligible Expenses in order to receive reimbursement from your HRA.

**Manual Claims Submission.** To receive reimbursement, you must submit a claim to your HRA for payment consideration. All claims must include a completed Health Care Claim Form, including any required supporting documentation. Health Care Claim Forms can be obtained from your Employer, [healthpartners.com](http://healthpartners.com) or by calling Member Services. Claims are paid based on the amount initially submitted. If the amount of the original claim later changes you must notify HealthPartners so that the claim can be adjusted.

To receive reimbursement from your HRA, claims may be submitted in one of the following ways:

- **Fax** a claim form and supporting documentation to HealthPartners at (952) 883-5026 or toll-free 1-877-624-2287; or
- **Mail** a claim form and supporting documentation to HealthPartners at:  
  
HealthPartners Service Center  
CDHP – Mail Route 21104T  
P.O. Box 297  
Minneapolis, MN 55440-0297
- **Online** – Log into [www.healthpartners.com](http://www.healthpartners.com) and select:
  - Medical Plan Services Tab
  - View all claims
  - My HealthPartners Account Balances
  - Details
  - Submit Health Care Claim

Supporting documentation includes at least one of the following:

- Explanation of Benefits (EOB) – the statement you receive each time a claim is submitted to your health plan.
- An itemized statement from the provider. The statement must show the provider name and address, patient name, date of service(s), description of service(s), and itemized charges.

Claims paid using HRA funds will be paid directly to the covered employee. You pay your provider's bill when it arrives.

The minimum reimbursement from your HRA is \$20 for the claims that you submit to your HRA for payment consideration. If your claim for Eligible Expenses is less than \$20 it will be considered an incomplete claim. Your claim will be considered complete and will be paid to you when your requested reimbursements for Eligible Expenses reach \$20. If your remaining election is less than \$20, the minimum reimbursement will be the balance of your remaining election.

You will be notified when your HRA balance reaches zero. At that time, you will be given your appeal options in the event that you believe that the determination was not correct. However, you will not be further notified, for the remainder of the plan year, that your account balance has reached zero. If, at any time, you have questions about your account balance, please call Member Services at (952) 883-7000 or 1-866-443-9352 toll-free. For hearing-impaired individuals, call (952) 883-5127 (TDD) or toll free at 1-888-850-4762 (TDD).

If it is later determined that you received an overpayment or a payment was made in error, the Plan reserves the right to require a refund or to offset future reimbursement equal to the overpayment or erroneous payment.

## B. CLAIMS PAYMENT FROM YOUR HRA

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

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

## C. CLAIM DENIALS AND CLAIM APPEALS PROCESS FOR CLAIMS PAYMENT FROM YOUR HRA

**For Claims Provisions and Complaint and Appeal Process applicable to the medical benefit portion of your Plan, you will need to refer to your Group Certificate.**

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

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

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

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

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

The time period may be extended if you agree.

All notifications described above will comply with applicable law.

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

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

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

The time periods may be extended if you agree.

All notifications described above will comply with applicable law.

3. **External Review Procedures.** You or your authorized representative must request an external review within 4 months of the adverse decision. If your claim is denied because of an adverse benefit determination, you have the right to request an external review, as described below.

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

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

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

- If you have an adverse benefit determination as defined above, you have the right to request external review.
- To initiate the external review process, you may submit a written request for an external review to the Plan Manager. A fee may be required.
- Upon receipt of the request for external review, the Independent Review Organization must provide immediate notice of the review to the complainant and to the Plan Manager. Within 10 business days, the Covered Person and the Plan Manager must provide the reviewer with any information they wish to be considered. The Covered Person (who may be assisted or represented by a person of their choice) and the Plan Manager shall be given an opportunity to present their versions of the facts and arguments. Any aspect of the external review involving medical determinations must be performed by a health care professional with expertise in the medical issue being reviewed.

An external review must be made as soon as possible, but no later than 40 days after receipt of the request for external review. Prompt written notice of the decision and the reasons for it must be sent to the Covered Person and to the Plan Manager.