



HealthPartners IndividualSM Plan

Summary of Benefits



The following summarizes your Midwest Assurance Company coverage. Your membership contract will provide complete details. If you have questions, call Member Services at 952-883-5000 or 1-800-883-2177. TTY call 952-883-5127 or 1-800-883-2177.

	Individual calendar year medical deductible*	Individual calendar year medical out-of-pocket maximum**	Individual calendar year prescription drug deductible	Individual calendar year prescription drug out-of-pocket maximum ***
* Limit of three deductibles per family per calendar year	\$150 \$300	\$850 \$1,300	None None	\$500 \$500
** Family out-of-pocket maximums are limited to three times the individual medical out-of-pocket maximum	\$500 \$750 \$1,000	\$1,300 \$1,500 \$2,000	\$250 \$250 \$500	\$750 \$750 \$1,000
*** Family out-of-pocket maximums are two times the individual prescription out-of-pocket maximums.	\$1,500 \$3,000 \$5,000	\$2,500 \$4,000 \$8,000	\$500 \$1,000 \$1,000	\$1,000 \$2,000 \$2,000
Lifetime maximum per person	\$2,000,000			

Plan services

HealthPartners Open Access network

When care is provided by or authorized by your HealthPartners Open Access physician.

Preventive health care

- Routine physical & eye examinations 80% coverage after deductible
- Well-Child Care 100% coverage to age 6, immunizations to age 18
- Prenatal Services 100% coverage

Office visits

- Illness or injury 80% coverage after deductible
- Chiropractic care 80% coverage after deductible, 15 visits per calendar year
- Mental health care 80% coverage after deductible
- Chemical health care 80% coverage after deductible, if elected and approved

Inpatient hospital care (365 days per period of confinement)

- Illness or injury 80% coverage after deductible
- Mental health care 80% coverage after deductible
- Chemical health care 80% coverage after deductible, if elected and approved
- Labor & Delivery No coverage for first 18 months, then 80% coverage after deductible

Outpatient care

- Scheduled outpatient procedures 80% coverage after deductible

Emergency care

- Emergency care 80% coverage after deductible

Plan services

HealthPartners Open Access network

Prescription drugs

- **Prescription Drugs**
At participating pharmacies;
up to a 30 day supply or
1 cycle of oral contraceptives
- \$150 - \$300 deductible plan:** 80% coverage with a \$10 min. and \$25 max. per prescription
- All other plans:** 80% after Rx deductible

Home health care

- **Home health care** 80% coverage after deductible, 120 visits per calendar year

Durable medical equipment

- **Durable medical equipment** 80% coverage after deductible

Out-of-network coverage

This plan offers coverage for out-of-network services. Covered benefits are subject to a separate out-of-network deductible and coinsurance. Please refer to a membership contract for complete details.

CareCheck® service (applies to out-of-network coverage)

To get the maximum benefits you must notify CareCheck at 952-883-5800 or 1-800-942-4872 about hospitalizations including medical emergencies and same-day surgeries outside the HealthPartners Open Access Network. Benefits will be reduced by 20 percent if CareCheck is not notified. A utilization management specialist will review your proposed treatment plan, determine length of stay, approve additional days when needed and review the quality and appropriateness of the care you receive. Please refer to a membership contract for further information.

Our approach to protecting personal information

As a health plan, we comply with federal and state laws regarding the confidentiality of medical records and personal information about our members and former members. We've developed policies and procedures to ensure that the collection, use and disclosure of such information complies with the law. Whenever necessary, we obtain consent or authorization from our members, or an approved member representative when the member is unable to give consent or authorization, for disclosure of personal information. We give members access to their own information consistent with applicable law and standards. Our policies and practices are designed to facilitate appropriate and effective use of information, internally and externally, to enable us to serve our members and improve the health of our members, our patients and the community, while being sensitive to their privacy. If you would like a copy of our privacy notice, please visit healthpartners.com or call Member Services at 952-883-5000 or 1-800-883-2177. Please contact your provider directly to obtain information about their privacy policy.

Appropriate use and coverage of prescription medications

We strive to provide our members with coverage of medications that are high quality, safe and cost-effective in several ways, including:

- A prescription drug formulary of medications that has been reviewed and approved for coverage based on quality, safety, effectiveness and value.
- A special program to assist members who require many different medications to avoid unintended drug interactions.

The list of prescription drugs on the formulary is on the HealthPartners Web site, along with information on how drugs are reviewed, the criteria used to determine which drugs are added to the formulary, how you can request coverage of nonformulary drugs, and more. You can also get this information from Member Services.

Provider Reimbursement

Our goal in reimbursing providers is to provide affordable care for our members while encouraging best care practices and rewarding providers for meeting the needs of our members. Several different types of reimbursement arrangements are used with providers. All are designed to achieve that goal.

Some providers are paid on a “**fee-for-service**” basis, which means that the health plan pays the provider a certain set amount that corresponds to each type of service furnished by the provider.

Some providers are paid on a “**discount**” basis, which means that when a provider sends us a bill, we have negotiated a reduced rate on behalf of our members. We pay a predetermined percentage of the total bill for services.

Some providers are paid a **salary**, with a possible additional payment made based on performance criteria, such as quality of care and patient satisfaction measures.

We pay some groups of providers on a “**capitated**” basis, which means that the provider group receives a set fee each month for each member enrolled in the provider group's clinic, regardless of how many or what type of services the member actually receives. Provider groups are, therefore, required to manage the budget for their entire patient panel appropriately.

Sometimes we have “**case rate**” arrangements with providers, which means that for a selected set of services the provider receives a set fee, or a “case rate”, for services needed up to an agreed upon maximum amount of services for a designated period of time.

Alternatively, we may pay a “case rate” to a provider for all of the selected set of services needed during an agreed upon period of time.

Sometimes we have “**withhold**” arrangements with providers, which means that a portion of the provider's payment is set aside until the end of the year. The year-end reconciliation can happen in one or more of the following ways:

- Withholds are sometimes used to pay specialty, referral or hospital providers who furnish services to members. The provider usually receives all or a portion of the withhold based on performance of agreed upon criteria, which may include patient satisfaction levels, quality of care and/or care management measures.
- Sometimes withholds are used to establish “cost targets” for care expenses. If total care costs are less than the withheld amounts, the remainder is returned to the clinic at the end of the year.

“Capitation” and “withhold” arrangements also include careful monitoring of the quality of care provided and “**stop-loss**” protections which reduce the chance that treating patients with costly illnesses will have a direct negative impact on the provider's financial situation. Stop-loss is a special kind of insurance coverage that helps to ensure that providers do not have an incentive to limit care simply because they are at financial risk for a portion of the cost of that care.

Some providers - usually hospitals - are paid on the **basis of the diagnosis** that they are treating; in other words, they are paid a set fee to treat certain kinds of conditions. Sometimes we pay hospitals and other institutional providers a set fee, or “**per diem**”, according to the number of days the patient spent in the facility.

Occasionally our reimbursement arrangements with providers include some **combination** of the methods described above. For example, we may capitate a provider for certain types of care and pay that same provider on a fee-for-service basis for other types of care. We also may pay a case rate to a provider for a selected set of services needed during an agreed upon period of time, or for services needed up to an agreed upon maximum amount of services, and pay that same provider on a fee-for-service basis for services that are not provided within the time period or that exceed the maximum amount of services. In addition, although we may pay a provider such as a medical clinic using one type of reimbursement method, that clinic may pay its employed providers using another reimbursement method.

Check with your individual provider if you wish to know the basis on which he or she is paid.

PLEASE NOTE: *Enrolling in this plan does not guarantee services by a particular provider on this list. If you wish to be certain of receiving care from a specific doctor listed, you should contact that doctor to ask whether or not the doctor is still a HealthPartners network provider and whether or not the doctor is accepting additional patients.*

Access to health care services does not guarantee access to a particular type of doctor. Please contact Member Services at 952-883-5000 or 1-800-883-2177 for specific information about access to different kinds of doctors.

HealthPartners negotiates with some providers to pay discounted rates. In those cases, coinsurance (a specific percentage of the charge) is based on that discounted amount. Copayments (flat amounts specified in advance for categories of service, such as office visits or prescriptions) are based on an aggregate of billed charges for that type of service.

Summary of Utilization Management Programs

Part of helping our members stay healthy is making sure they get the care they need when they need it. To help coordinate effective, accessible and high quality health care, HealthPartners uses utilization management programs. These programs are based on the study of patient populations to evaluate appropriate levels of care and establish guidelines for the best medical practices using the most up-to-date medical evidence.

Our utilization management programs include activities to reduce the underuse, overuse and misuse of health services. These programs include:

- Inpatient concurrent review and care coordination to support timely care and ensure a safe and timely transition from the hospital
- “Best practice” care guidelines for selected kinds of care
- Outpatient case management to provide care coordination
- The CareCheck® program to coordinate out-of-network hospitalizations

Prior approval is required for a small number of services and procedures. These are listed on healthpartners.com and are also available by calling Member Services. Typically, your doctor will request this approval on your behalf. Decisions are based on coverage criteria that are posted on the Web site and available from Member Services.

HealthPartners does not employ incentives that encourage barriers to care and service. Our Outcomes Recognition Program rewards doctors who achieve the highest levels of quality and service to patients.

Services not covered

For details about benefits and services, call HealthPartners Member Services at 952-883-5000 or 1-800-883-2177.

After you enroll, you will receive identification cards, a Member Handbook and a Membership Contract, which explains exact coverage terms and conditions. *This health care plan does not cover all health care expenses.* In general, any service not provided by or under the direction of a licensed physician is not covered. The following is a *summary* of items which are excluded or limited:

- Treatment, services or procedures which are experimental, investigative or are not medically necessary
- Dental care or oral surgery†
- Non-rehabilitative chiropractic services
- Eyeglasses, contact lenses, hearing aids and their fittings
- Private-duty nursing; rest, respite and custodial care†
- Cosmetic surgery†
- Vocational rehabilitation; recreational or educational therapy
- Sterilization reversal and artificial conception processes†
- Physical, mental or substance-abuse examinations done for or ordered by third parties†
† *except as specifically described in the Membership Contract*

Notice: This disclosure is required by Minnesota law. This policy or certificate is expected to return on average 78.5% of your premium dollar for health care. The lowest percentage permitted by state law for this policy or certificate is 78.5%.

Service Area: You must be a Minnesota resident to purchase this plan. The HealthPartners network of medical providers continues to grow in order to meet the needs of our members, but access to all provider types is not guaranteed. Please call Member Services for a current list.

HealthPartners.com

For lots of great information about HealthPartners health plans, go online at healthpartners.com. You'll find frequently asked questions, the prescription drug formulary list, services that require prior approval for coverage, health information and resources, and much more. It's a great resource to help you get the most from your plan. If you have questions or would like information sent to you, call Member Services at 952-883-5000 or 1-800-883-2177.

This health care plan may not cover all health care expenses.
Read your membership contract carefully to determine which expenses are covered.



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Our mission is to improve the health of our members, our patients, and the community.