



## HealthPartners Individual<sup>SM</sup> Plan

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*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	\$850	None	\$500
	\$300	\$1,300	None	\$500
** Family out-of-pocket maximums are limited to three times the individual medical out-of-pocket maximum	\$500	\$1,300	\$250	\$750
	\$750	\$1,500	\$250	\$750
	\$1,000	\$2,000	\$500	\$1,000
	\$1,500	\$2,500	\$500	\$1,000
	\$3,000	\$4,000	\$1,000	\$2,000
	\$5,000	\$8,000	\$1,000	\$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 minimum and a \$25 maximum 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](http://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 quality care through 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.

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:

- Withhold arrangements are sometimes used to pay primary care, specialty, referral or hospital providers who furnish services to members. The provider usually receives all or a portion of the withheld amount based on performance of agreed upon criteria, which may include patient satisfaction levels, quality of care and/or care management measures along with the financial performance of HealthPartners. Certain factors are measured to determine if the provider has satisfied the withhold criteria, such as patient satisfaction, survey results and compliance with industry standards for preventative services, clinical guidelines and care management.
- Sometimes the amount of the withhold that the provider receives is based upon "cost targets" for care expenses. If total care costs are less than the cost target, all or a portion of the withheld amount is returned to the provider after the end of the year. Such cost targets include "stop-loss" protections which reduce the chance that treating patients with costly illnesses will have a direct negative impact on the provider's performance.

A provider may qualify to participate in a bonus program and receive additional payment if the provider meets certain performance criteria. Generally, these performance criteria are similar to the withhold criteria described above.

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,” for each day or 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 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. Please 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 doesn't guarantee services by a particular provider. If you wish to be certain of receiving care from a specific doctor, 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 doesn't 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 types of doctors.*

## 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](http://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 you can use, visit [healthpartners.com](http://healthpartners.com). You'll find frequently asked questions, the prescription drug formulary, services that require prior approval for coverage, health information and resources, and more. Members can log on and take care of lots of health plan business conveniently –check their claims status, refill prescriptions, make appointments, estimate their medical costs and much more. It's a great resource to help you get the most value from your plan. If you have questions or would like information sent to you, please 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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[healthpartners.com](http://healthpartners.com)

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