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 patient consent for disclosure of personal information and we give members access to their own information consistent with applicable law. Our policies and practices are designed to facilitate appropriate and effective use of information, internally and externally. If you'd like to receive a copy of our privacy notice, please call Member Services at 952-883-5036 or 1-888-922-2313. For your provider's privacy policy, please contact your provider directly.

When you enroll in the Empower Plan, your medical claims are sent automatically and electronically to the vendor that administers your Health Reimbursement Account (HRA) for plan administrative purposes. By enrolling, you are authorizing the release of you and your dependent's medical claims information. You can view certain limited information of all family members enrolled the Empower Plan on the HRA account web site. By enrolling, you're acknowledging that you and all dependents enrolled in the Empower 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.

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. We do this in several ways, including use of:

- A prescription drug formulary of medications that has been reviewed and approved for coverage based on quality, safety, effectiveness and value.
- A 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.

Services Not Covered

After you enroll, you'll receive an ID card, a Member Handbook and a Membership Contract that explains exact coverage terms and conditions. This health care plan does not cover all health care expenses. Some services may require a referral from a plan provider, and any service not provided by or under the direction of a licensed physician, is not covered. Here is a summary of excluded or limited items:

- Treatment, services or procedures which are experimental, investigative or are not medically necessary
- Acupuncture
- Dental care or oral surgery, including orthognathic†
- Non-rehabilitative services
- Drugs for the treatment of sexual dysfunction
- Eyeglasses, contact lenses, hearing aids and their fittings
- Private-duty nursing; rest, respite and custodial care†
- Cosmetic surgery†
- Weight loss services, surgery and prescription drugs
- 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

For details about benefits and services, call HealthPartners Member Services at 952-883-5036 or 1-888-922-2313.

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 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 952-883-5036 or 1-888-922-2313.

THIS HEALTH CARE PLAN MAY NOT COVER ALL YOUR HEALTH CARE EXPENSES; READ YOUR MEMBERSHIP CONTRACT CAREFULLY TO DETERMINE WHICH EXPENSES ARE COVERED.

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 prescriptions) are based on an aggregate of billed charges for that type of service. This disclosure is required by Minnesota law.

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

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Empower Midwest Choice℠ Plan

High Deductible Health Plan (HDHP) for Individuals

Summary of Benefits

This plan is intended to qualify as a high deductible health plan that may be paired with a Health Savings Account (HSA); however, you should check with your tax advisor for guidance on your particular situation.

The following summarizes your Midwest Assurance Company coverage. For exact terms and conditions, consult a Midwest Assurance Certificate of Coverage, or call Member Services Information Line at 952-883-5036, or call toll free at 1-888-922-2313.

HIGHLIGHTS	80% PLAN		100% PLAN	
Calendar year deductible options	Individual	Family	Individual	Family
	$1,200 $2,000	$2,400 $4,000	$2,600 $5,000	$5,150 $10,000
Calendar year out-of-pocket	$2,400 $4,000	$4,800 $8,000	Equal to deductible amount	
Lifetime maximum	2 million		2 million	
Office visits for illness, injury, eye exams and physicals	80% after deductible		100% after deductible	
Inpatients and outpatient hospital services	80% after deductible		100% after deductible	
Emergency room care and ambulance service	80% after deductible		100% after deductible	
Durable medical equipment	80% after deductible		100% after deductible	
Chiropractic, occupational, physical and speech therapy	80% after deductible		100% after deductible	
Well-child services to age 6; immunizations to age 18	100% (deductible doesn't apply)		100% (deductible doesn't apply)	
Home health care	80% after deductible		100% after deductible	
Formulary prescription drugs	80% after deductible		100% after deductible	
Behavioral health care	80% after deductible		100% after deductible	
Prenatal care	100% (deductible doesn't apply)		100% (deductible doesn't apply)	
Delivery and post-delivery care	No coverage for the first 18 months of coverage. Beginning with the 19th month of coverage: 80% after deductible.		No coverage for the first 18 months of coverage. Beginning with the 19th month of coverage: 100% after deductible.	
Out-of-network services	This plan covers 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.

Deductibles and out-of-pocket maximums are based on the Consumer Price Index and may change annually.

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,
- 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 952-883-5036 or 1-888-922-2313 for specific information about access to different kinds 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 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.