



## Empower Midwest Choice<sup>SM</sup> Plan

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*High Deductible Health Plan (HDHP)  
for Individuals*

*Summary of Benefits*



**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 952-883-7000, or call toll free at 1-866-443-9352.**

*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.*

HIGHLIGHTS	80% PLAN		100% PLAN	
	Individual	Family	Individual	Family
Calendar year deductible options	\$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 twenty 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.

## 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 952-883-7000 or 1-866-443-9352. For your provider's privacy policy, please contact your provider directly.

## 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.

When you choose a brand name drug you'll pay the cost difference between it and the generic equivalent, plus the applicable copayment or coinsurance. If no generic equivalent is available, you pay only the applicable copayment or coinsurance.

## 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. In general, 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

### **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 952-883-7000 or 1-866-443-9352.

For details about benefits and services, call HealthPartners Member Services at 952-883-7000 or 1-866-443-9352.

**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. This disclosure is required by Minnesota law.



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

## 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 952-883-7000 or 1-866-443-9352 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.