McAlpin Agency, Inc.
3990 Central Avenue NE
Columbia Heights, MN 55421
(763) 788-9274
www.mcalpinagency.com

HealthPartners® Short Term Health Plan

Summary of Benefits

Affordable, temporary coverage
when you need immediate protection

The HealthPartners Short Term Health Plan provides temporary health care coverage when you need it.

The plan gives you the freedom of choice and instant protection at a low cost. You enjoy access to our more than 470,000 providers and 4,800 hospitals nationwide, and there are no referrals to see a specialist.

Simple enrollment for peace of mind

Getting short term health coverage is easy. Complete and return the brief enrollment form that is included in your packet or download a form at **healthpartners.com/individual**.

Our friendly consultants are available to help you complete the form and answer your questions. Call our sales experts at 952-883-5600 or 800-247-7015 between 8 a.m. and 6 p.m. Monday – Friday.

Plan options present flexibility and affordability

Choose from three lengths of time and four deductible amounts to create a plan that fits your needs. Generally, higher deductible plans have lower monthly premium rates.

HealthPartners gives you the affordable coverage you need

This plan offers you peace of mind in the event of a medical emergency. Our coverage includes:

- Office visits for illness or injury
- Prescription drugs (some drug categories, such as contraceptives, weight loss, sleep aids, tobacco cessation and drugs prescribed to treat a pre-existing condition, are not covered; refer to a Certificate of Coverage for more details)
- Emergency and urgent care
- Ambulance services
- Hospitalization
- X-rays and lab work

The HealthPartners Short Term Health Plan is great coverage to have while your application for a long term individual plan is being processed.

Short term coverage does not cover pre-existing conditions; physical, occupational and speech therapy; childbirth; transplants; mental health; preventive care (except as required per mandates); and some other services – refer to a Certificate of Coverage for more information.

A pre-existing condition is, with respect to coverage, any injury, illness or condition for which the insured(s) has received medical treatment, care, advice or diagnosis, symptoms or a manifestation before the effective date of the coverage.

Healthy discounts to keep you well

With HealthPartners, you can stretch your health care dollar even further. We offer great perks available exclusively to HealthPartners members, including GlobalFit fitness club discounts and savings on exercise equipment, classes, snowboard and ski equipment, spa and wellness services and more. Visit the Healthy Discounts section of **healthpartners.com** for more details.

We offer other options if your needs change

We realize that your health care needs change over time, and you and your family may need a more permanent solution. HealthPartners also offers affordable and comprehensive individual health plans designed to accommodate your life. Choose from a wide range of deductible options, including plans that can be paired with a tax-advantaged Health Savings Account.

Visit **healthpartners.com/individual** for more information.

Summary of Benefits

The following is a brief summary of your Short Term HealthPartners Insurance Company coverage. For a detailed description of terms and conditions, refer to a HealthPartners Insurance Certificate of Coverage or call our friendly and knowledgeable staff at 952-883-5600 or 800-247-7015.

	Plan 1 $300-80%	Plan 2 $500-80%	Plan 3 $1,000-80%	Plan 4 $2,000-100%
Coverage Lengths Available	30, 60 or 90 days	30, 60 or 90 days	30, 60 or 90 days	30, 60 or 90 days
In Network Deductible (per person)	$300	$500	$1,000	$2,000
In Network Out of Pocket Maximum (per person)	$1,500	$1,500	$3,000	$2,000
Office Visits	80% after deductible	80% after deductible	80% after deductible	100% after deductible
Prescription Drugs (excluding birth control)	80% after deductible	80% after deductible	80% after deductible	100% after deductible
Emergency and Urgent Services	80% after deductible	80% after deductible	80% after deductible	100% after deductible
Inpatient and Outpatient Hospital Care	80% after deductible	80% after deductible	80% after deductible	100% after deductible
Ambulance	80% after deductible	80% after deductible	80% after deductible	100% after deductible
Outpatient MRI and CT	80% after deductible	80% after deductible	80% after deductible	100% after deductible
Laboratory Services	80% after deductible	80% after deductible	80% after deductible	100% after deductible
Home Hospice Services	80% after deductible	80% after deductible	80% after deductible	100% after deductible
Child Health Supervision to age 6	100% (no deductible)	100% (no deductible)	100% (no deductible)	100% (no deductible)
Immunizations to age 18	100% (no deductible)	100% (no deductible)	100% (no deductible)	100% (no deductible)
Out of Network Deductible (per person)	$1,500	$1,500	$3,000	$6,000
Out of Network Out of Pocket Maximum (per person)	No Limit	No Limit	No Limit	No Limit
Out of Network Coverage	40% after deductible	40% after deductible	40% after deductible	50% after deductible
Lifetime Maximum (per person)	$1,000,000	$1,000,000	$1,000,000	$1,000,000
Health Savings Account Eligible?	No	No	No	Yes

Pharmacy Benefit Details

With this plan, you pay in full for your prescription at the pharmacy. When you show your HealthPartners member ID card, you gain the advantage of our contracted discounts at more than 60,000 pharmacies nationwide. If the medication you fill is used to treat a newly diagnosed condition and is not excluded per the terms of your contract, you can submit your pharmacy claim for review and application to your deductible. Once the claim is reviewed, and you've reached your deductible, you will receive a reimbursement check.

A step by step guide on how to enroll in and use the HealthPartners Short Term Health Plan

1. Choose the length of coverage and deductible amount you need.
2. Complete and return the brief enrollment form, along with your full payment (see premium worksheet to determine the correct amount).
3. Your coverage begins immediately after your application is accepted and we receive your full payment.
4. If you need to find a doctor or hospital, visit **healthpartners.com** or call Member Services to locate a provider in our network.
5. When you visit a provider in our large network, you pay the in network deductible you selected on your application.
6. After you reach your deductible, HealthPartners pays for 80-100% (depending on the coverage you've chosen) of all covered medical expenses. This is known as coinsurance.

Example - Plan Option 1: $300-80% for 30 days

Qualifying medical bill - $2,600 for broken arm

You Pay:		HealthPartners Pays:
Plan Premium	$60	80% coinsurance $1,840
Deductible	$300	
20% coinsurance	$460	
Your total responsibility	$820	
You save $1,840		

7. If you find that you need longer coverage, you may apply for another short term plan or one of HealthPartners other individual health plans. Visit **healthpartners.com/individual** for more information.

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8170 33rd Avenue South
P.O. Box 1309
Bloomington, MN 55425

healthpartners.com

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Important Information on the HealthPartners Short Term Health Plan

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.

Our approach to protecting personal information

HealthPartners complies with federal and state laws regarding the confidentiality of medical records and personal information about our members and former members. Our policies and procedures help ensure that the collection, use and disclosure of information complies with the law. When needed, we get consent or authorization from our members (or an approved member representative when the member is unable to give consent or authorization) for release of personal information. We give members access to their own information consistent with applicable law and standards. Our policies and practices support appropriate and effective use of information, internally and externally, and enable us to serve and improve the health of our members, our patients and the community, while being sensitive to privacy. For 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 for a copy of the HealthPartners privacy notice.

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

© 2007 HealthPartners

HealthPartners Short Term Health Plan

Underwritten by HealthPartners Insurance Company

Premium Worksheet

Use this worksheet to calculate your premium rates and submit your payment for coverage by the HealthPartners Short Term Health Plan. *Rate tables for this plan appear on the back of this page.*

The premium for this plan is determined by the age of each individual seeking coverage, your plan selection, where you live and the number of days you wish to be covered.

If you are a single adult applicant, simply locate the appropriate rate for your age, location and plan selection from the rate table and add the $20 application fee.

Covering a spouse or dependents?
To calculate a family premium, find the appropriate rates for your self and adult spouse. Add in amount(s) for any child dependent(s) ages 90 days to 25 years old, plus the $20 application fee. Premiums are charged for a maximum of three children per family, and only one plan and coverage term is allowed per family. If you are buying the plan on behalf of a child, ages 90 days to 18 years only, use the 90 days to 18 age rate for the oldest child. Any additional children will be charged the dependent child rate.

Important
If you or your spouse have a birthday during the policy term, and it moves you into a different age bracket, you will need to adjust your premium amount accordingly. For help, call HealthPartners Individual Sales at 952-883-5600 or 800-247-7015 between 8 a.m. and 6 p.m. Monday-Friday.

HealthPartners requires payment in full at time of enrollment, including the $20 application fee. If you do not include full payment, your application will be returned to you. If you are ineligible for coverage, your entire payment will be returned to you.

Calculate your premium

Applicant Rate		$ ____________
Spouse Rate		$ ____________
Dependent Child Rate	Child 1	$ ____________
	Child 2	$ ____________
	Child 3	$ ____________
Application Fee		$ $20.00
Total Premium and Application Fee		$ ____________

Choose your method of payment

_____ I have enclosed a check for the Total Premium and Application Fee.

_____ Charge my credit card for the Total Premium and Application Fee.

_____ Visa _____ MasterCard _____ American Express _____ Discover

Card Number ____________________

Exp. Date ________ / ________

Signature ______________________________

Return this premium worksheet with your Short Term Health Plan enrollment form.

Copyright 2007 HealthPartners

The HealthPartners family of health plans are underwritten and administered by HealthPartners, Inc., Group Health, Inc. or HealthPartners Administrators, Inc.

Age	30 Days			
	$300 - 80%	$500 - 80%	$1,000 - 80%	$2,000 - 100%
90 Days - 18	$71.15	$53.75	$43.15	$36.45
19 - 24	$65.85	$49.75	$39.95	$33.75
25 - 29	$65.85	$49.75	$39.95	$33.75
30 - 34	$73.70	$55.80	$44.90	$37.95
35 - 39	$77.10	$58.30	$47.00	$39.70
40 - 44	$86.90	$66.15	$53.50	$45.20
45 - 49	$110.40	$84.20	$68.40	$57.80
50 - 54	$148.60	$113.75	$92.80	$78.40
55 - 59	$189.70	$145.75	$119.25	$100.75
60 - 64	$197.55	$149.25	$119.85	$101.25
1 Child	$53.85	$41.80	$34.55	$29.20
2 Children	$107.70	$83.60	$69.10	$58.40
3+ Children	$161.55	$125.40	$103.65	$87.60

Age	60 Days			
	$300 - 80%	$500 - 80%	$1,000 - 80%	$2,000 - 100%
90 Days - 18	$142.30	$107.50	$86.30	$72.90
19 - 24	$131.70	$99.50	$79.90	$67.50
25 - 29	$131.70	$99.50	$79.90	$67.50
30 - 34	$147.40	$111.60	$89.80	$75.90
35 - 39	$154.20	$116.60	$94.00	$79.40
40 - 44	$173.80	$132.30	$107.00	$90.40
45 - 49	$220.80	$168.40	$136.80	$115.60
50 - 54	$297.20	$227.50	$185.60	$156.80
55 - 59	$379.40	$291.50	$238.50	$201.50
60 - 64	$395.10	$298.50	$239.70	$202.50
1 Child	$107.70	$83.60	$69.10	$58.40
2 Children	$215.40	$167.20	$138.20	$116.80
3+ Children	$323.10	$250.80	$207.30	$175.20

Age	90 Days			
	$300 - 80%	$500 - 80%	$1,000 - 80%	$2,000 - 100%
90 Days - 18	$213.45	$161.25	$129.45	$109.35
19 - 24	$197.55	$149.25	$119.85	$101.25
25 - 29	$197.55	$149.25	$119.85	$101.25
30 - 34	$221.10	$167.40	$134.70	$113.85
35 - 39	$231.30	$174.90	$141.00	$119.10
40 - 44	$260.70	$198.45	$160.50	$135.60
45 - 49	$331.20	$252.60	$205.20	$173.40
50 - 54	$445.80	$341.25	$278.40	$235.20
55 - 59	$569.10	$437.25	$357.75	$302.25
60 - 64	$592.65	$447.75	$359.55	$303.75
1 Child	$161.55	$125.40	$103.65	$87.60
2 Children	$323.10	$250.80	$207.30	$175.20
3+ Children	$484.65	$376.20	$310.95	$262.80

Plans include chemical dependency coverage.

Rates are subject to change.

HealthPartners®
Your health. Your partner.

HealthPartners Short Term Health Care Coverage

ENROLLMENT FORM/EVIDENCE OF INSURABILITY
Send completed enrollment form, or direct questions to: HealthPartners Individual Sales Department - P.O. Box 1309 - MS21106D - Minneapolis, MN 55440-1309. Fax 952-853-8718. Phone 952-883-5600 or 1-800-247-7015.

Please write all answers in ink. Answer all questions completely to avoid delay in enrollment processing.

Applicant Information

Last Name *(person responsible for payment)* | First Name | M.I.

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

Lead Applicant's Address | City | State | Zip

Lead Applicant's Home Telephone (include area code)
(______) ______ - _________

Work Telephone (include area code)
(______) ______ - ________

Email Address
___________________ @ __________________

Dependent's Address (if different from above) | City | State | Zip
Add additional page(s) for dependents if necessary.

Reason for application: (check one)

- ☐ I am a new applicant.
- ☐ I am reapplying for HealthPartners Short Term Health Plan coverage after having been denied for it.
- ☐ I am currently covered by a HealthPartners Short Term Health Plan.
- ☐ I am currently covered by a different HealthPartners Plan.

Have you or any family member(s) included in this enrollment form been covered by short term coverage by any health carrier within the past 555 days? .... ☐YES ☐ NO
If YES, how many days were you or your family member(s) covered by short term coverage? ______________ days
If YES, your new policy must have a deductible equal to or greater than and a plan period equal to or less than your current/former policy. State law prohibits you from having short term coverage from any health carrier for more than 365 of the past 555 days.

Dependent Information: Complete the following information for each person to be covered.

FULL NAME *(start with yourself)*	AGE	RELATIONSHIP	SEX	DATE OF BIRTH	SOCIAL SECURITY #	HEALTHPARTNERS MEMBER NUMBER *(if ever been a member)*

Plan Information

Choose only one of the following deductible plans: ☐ $300 - 80% ☐ $500 - 80% ☐ $1,000 - 80% ☐ $2,000 - 100%

Requested Effective Date (mm/dd/yy) ____/____/____

HealthPartners will notify you as to the actual effective date. The effective date is the day we receive the enrollment form and full payment in our office, or the requested effective date, whichever is later provided the effective date is no more than 60 days beyond the signature date of your enrollment form.

Number of Days Coverage Requested ☐ 30 ☐ 60 ☐ 90

Eligibility Information

	YES	NO
Is the Lead Applicant (applicant seeking to be primary insured or contract holder) less than 90 days of age or older than 64 years?	☐	☐
Is any person applying for coverage NOT a legal resident or citizen of the United States?	☐	☐
Does any person applying for coverage:		
Have other health care insurance coverage in force during the period for which coverage is requested, including Medicare? *(Health care insurance coverage does not include any applications currently pending.)*	☐	☐
Have a history of being declined insurance by any health carrier?	☐	☐
Is any person applying for coverage:		
Currently pregnant; or is your spouse, significant other, or other dependent currently pregnant or do you plan to add a dependent as a result of a birth or adoption?	☐	☐
Planning to add any other dependent?	☐	☐
Currently confined to or in any health care facility?	☐	☐
Consulting a medical professional for weight or related concerns?	☐	☐
Within the past five years, has any person applying for coverage had a diagnosis of, received treatment for, or consulted with a provider concerning:		
Heart disorder, stroke or other circulatory disorder?	☐	☐
Cancer?	☐	☐
Diabetes?	☐	☐
Multiple Sclerosis, Lupus, rheumatoid arthritis or any other auto-immune disorder?	☐	☐
Crohn's Disease or ulcerative colitis?	☐	☐
Kidney disorder or liver disorder?	☐	☐
Alcohol/chemical dependency or abuse?	☐	☐
Chronic lung disorder?	☐	☐
Chronic blood disorder?	☐	☐

STOP!

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS THE POLICY CANNOT BE ISSUED.

Conditions not specifically listed in the questions above may still not be covered if they are preexisting conditions. Please see the Signature & Acknowledgement section for a definition of pre-existing conditions.

If you have any questions about this application, please contact HealthPartners Individual Sales department at 952-883-5600 or 1-800-247-7015. Or log onto **healthpartners.com/individual**.

Signature & Acknowledgment

I hereby apply for coverage on the basis of the statements and answers to the questions herein. I hereby declare all answers to be true and complete to the best of my knowledge and to accurately represent the health of those persons applying for coverage. I understand that these statements, answers and subsequent information I provide are the basis for my coverage and will be made a part of my HealthPartners Short Term Health Plan contract. I understand that I must update this enrollment form to include any change in condition or disease affecting applicants for this coverage, that occur between the date I complete and sign this enrollment form and the date HealthPartners receives this enrollment form or the requested effective date for coverage, whichever is later. I understand that providing false information or omitting relevant information on this enrollment form may result in the denial of claims or rescission of coverage back to the effective date of coverage.

I understand that I and the other applicants listed on this enrollment form may be ineligible for coverage. If I have been a HealthPartners short term individual plan member in the past with claims investigated for fraud, I understand that I may not be eligible for enrollment at HealthPartners discretion. I understand that I am applying for an instant issue policy and may not withdraw my enrollment form once submitted. I understand that full payment must be submitted with this enrollment form or the policy will not be issued. I understand that if my dependent applicants and I are eligible for coverage and a policy is approved and issued, HealthPartners will notify me of the effective date of such policy. The effective date of coverage is the day HealthPartners receives this enrollment form or the effective date requested, whichever is later, provided that the effective date is no more than 60 days beyond the signature date on this enrollment form. Furthermore, I understand that the only dependents that can be added under this policy are children who are newly born or adopted per state law.

I understand that pre-existing conditions are not covered by this plan. A pre-existing condition is, with respect to coverage, any injury, illness, or condition for which the insured(s) has received medical treatment, care, advice or diagnosis, symptoms, or a manifestation before the effective date of the coverage. I also understand that any condition discovered and or treated during the term of this short term policy will be deemed a pre-existing condition in any subsequent short term policy to continue coverage and will not be covered by the subsequent policy.

I understand that if I terminate this short term coverage, that no cash refund will be issued. However, if HealthPartners approves my concurrent application for conventional individual coverage and such coverage is offered and accepted, HealthPartners may apply, with my consent, any pre-paid premium from this short term plan to my HealthPartners conventional individual plan.

I authorize HealthPartners to obtain from providers of service and hospitals, the medical records (including mental and chemical health) relating to me and all other applicants that are necessary for: claims processing, including claims we make for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, case management, care coordination and utilization management, disease management, the evaluation of potential or actual claims against us, fraud and abuse investigations, auditing and legal services, and other access and use without further authorization if permitted or required by another law. I also authorize HealthPartners to release information related to my HealthPartners enrollment (including information from my medical records) to my insurance broker. A photocopy of this authorization shall be as valid as the original and remains in effect unless it is revoked I understand that some clinics may require a separate authorization for the release of information for the purposes listed above. I agree to sign such releases for such purposes.

I authorize HealthPartners to release information related to my HealthPartners enrollment (including information from my medical records) to the lead applicant. This authorization is intended to cover the release of information described above related to me, my spouse, and my minor dependent children for whom I have applied for HealthPartners Short Term Health Plan coverage.

Please keep a copy of the completed enrollment form for your records. It will become a part of your contract if the enrollment is accepted.

All adult enrollees and the parent/legal guardian of all minor enrollees must sign here. Dependent children age 18 and older must sign.

X______________________________ Date__________
Signature of Primary Proposed Insured

X______________________________ Date__________
Signature of Spouse or Other Insured (if proposed to be insured)

X______________________________ Date__________
Signature(s) of Other Dependents 18 or Older

X______________________________ Date__________
Signature(s) of Other Dependents 18 or Older

Any person who submits an enrollment form or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Broker's name, if applicable. (Please print.) Steve McAlpin Broker # D 582 Date__________

HealthPartners Short Term Health Plan

Underwritten by HealthPartners Insurance Company

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HealthPartners requires payment in full at time of enrollment, including the $20 application fee. If you do not include full payment, your application will be returned to you. If you are ineligible for coverage, your entire payment will be returned to you.

Calculate your premium

Applicant Rate		$ ____________
Spouse Rate		$ ____________
Dependent Child Rate	Child 1	$ ____________
	Child 2	$ ____________
	Child 3	$ ____________
Application Fee		$ $20.00
Total Premium and Application Fee		$ ____________

Choose your method of payment

______ I have enclosed a check for the Total Premium and Application Fee.

______ Charge my credit card for the Total Premium and Application Fee.

______ Visa ______ MasterCard ______ American Express ______ Discover

Card Number ____________________

Exp. Date ________ / ________

Signature ______________________________

Return this premium worksheet with your Short Term Health Plan enrollment form.