HealthShare™
A HEALTH COVERAGE PROGRAM

Report to the Legislature

Community-Based Health Care Coverage Program

Minnesota Statutes 2007, Section 62Q.80
January 2010

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Duluth MN 55802
218-336-5710
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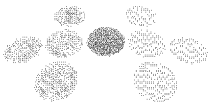

HealthShare™

A HEALTH COVERAGE PROGRAM

January 2010

Dear Policymakers:

We are pleased to provide this report on HealthShare, the Community-Based Health Coverage Program authorized by Minnesota Statute 2007,62Q.80.

Once legislation was passed and funding secured after the 2008 legislative session, HealthShare incorporated as a not-for-profit organization governed by a community board as specified in the legislation. From August through Novemeber 2008, staff were hired and the program infrastructure was developed. Nearly all of the local health care provider organizations in the initial target area surrounding Duluth signed agreements to participate in HealthShare.

HealthShare was offically launched in southern St. Louis County on November 14, 2008 with a widely publicized press conference that included state and local elected officals, representatives from business, local health care organizations, and key community leaders. Unfortuantely, this launch occurred amidst the worst finacial crisis since the Great Depression. As HealthShare staff attempted to enroll area businesses, owners were reluctant to take on an additional expense during uncertain economic times. Business owners acknowledged that the program was affordable at $60 per month per employee, with a similar contribution from employees, however they could not risk increasing costs in difficult times.

As of December 31, 2009, 55 members were enrolled in HealthShare. The original projection was to enroll 200 members in the first year. During the final months of 2009, enrollment increased gradually. We anticipate that this trend will continue through 2010 as signs in the economy improve.

One of the main features of HealthShare is the focus on wellness and preventive care. All members complete a health risk appraisal. Care management is an important component for those with a chronic health condition. Members who select the Wellness Plan establish two health goals and work with the nurse care mananger on strategies to accomplish their personal goals. Those enrolled in the Wellness Plan have a lower monthly fee and lower co-pays. Information on care management is included in this report.

In September, Minnesota's Department of Human Services was notified that it was one of 13 states to receive funding under the federal State Health Access Program. HealthShare is one of three local coverage program participating in this statewide effort.

Thank you for the opporuntity to present this report on the progress HealthShare has made during its initial year. If you have further questions, please contact me at 218-336-5702.

Sincerely,

Daniel L. Svendsen
Executive Director

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HealthShare Annual Report

November 30, 2008 – December 31, 2009

By

Michael D. Finch, Ph.D.
Finch and King, Inc.

This document is the required semiannual progress report for HealthShare. This report covers the time November 30, 2008 through December 31, 2009.

The report is divided into three sections. The first documents the firms enrolled in HealthShare, the second characteristics of enrollees and the third the costs of the program.

Section 1: Characteristics of Firms Participating in HealthShare

Table 1.1 is a copy of HealthShare's sales report maintained and provided by HealthShare (HealthShare Sales Report Through 2009.xls).

It documents sales contacts for the time period July 1, 2009 through December 31, 2009.

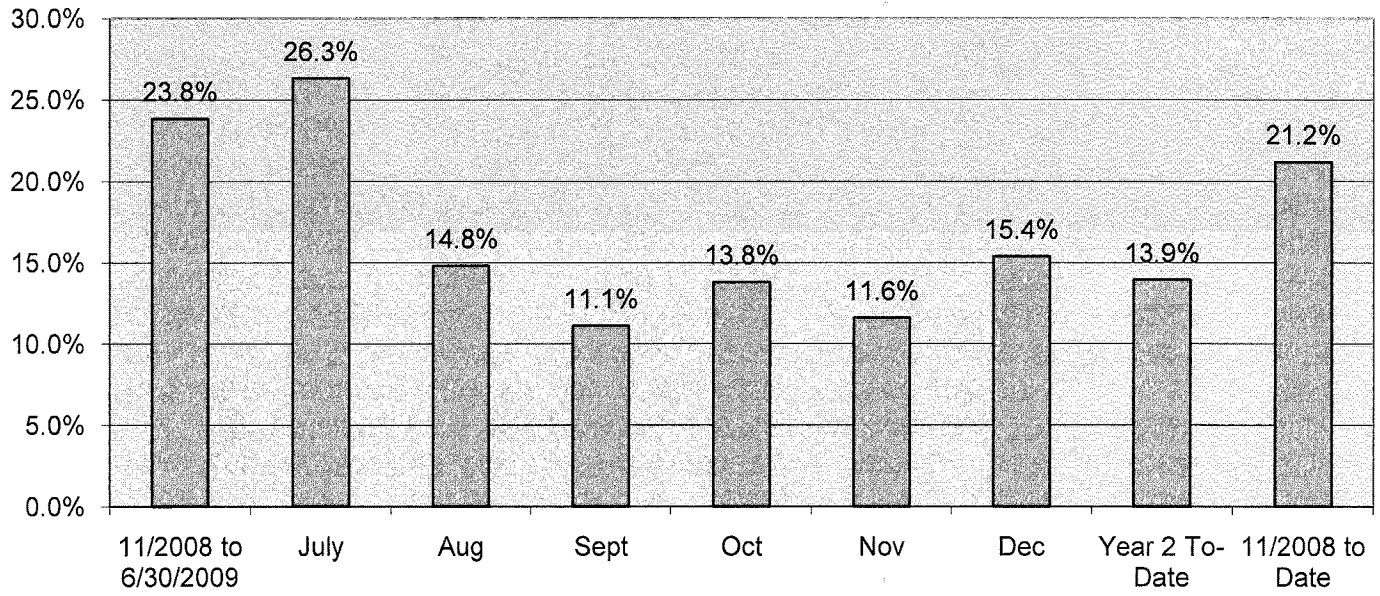
Table 1.1: HealthShare Sales Report through December 31, 2009

	Year 1	Year 2 July 1, 2009 Through December 31, 2009							All Years
	11/2008 to 6/30/2009	July	Aug	Sept	Oct	Nov	Dec	Year 2 To-Date	11/2008 to Date
Number of Businesses Contacted	902	19	27	63	87	69	65	330	1232
- Direct Contact	727	19	27	47	87	54	42	276	1003
- Via Mail	175	0	0	16	0	15	23	54	229
Number of Contacted Businesses Documented as Not Qualified	215	5	4	7	12	8	10	46	261
% of Contacted Businesses Not Qualified	23.8%	26.3%	14.8%	11.1%	13.8%	11.6%	15.4%	13.9%	21.2%
Number of Qualified Businesses Contacted (Includes businesses currently documented as not qualified)	687	14	23	56	75	61	55	284	971
Number of Businesses Not Interested	338	0	10	18	21	28	15	92	430
Active Follow-ups		76	68	75	83	79	73		
Number of Businesses Enrolled	9	4	1	3	1	2	1	12	21
% of Qualified Businesses Enrolled	1.3%	28.6%	4.3%	5.4%	1.3%	3.3%	1.8%	4.2%	2.2%
Number of Members Enrolled Initially	25	11	5	7	5	6	4	38	63

Three points from Table 1.1 are noteworthy. The first two are detailed below in figures 1.1 and 1.2.

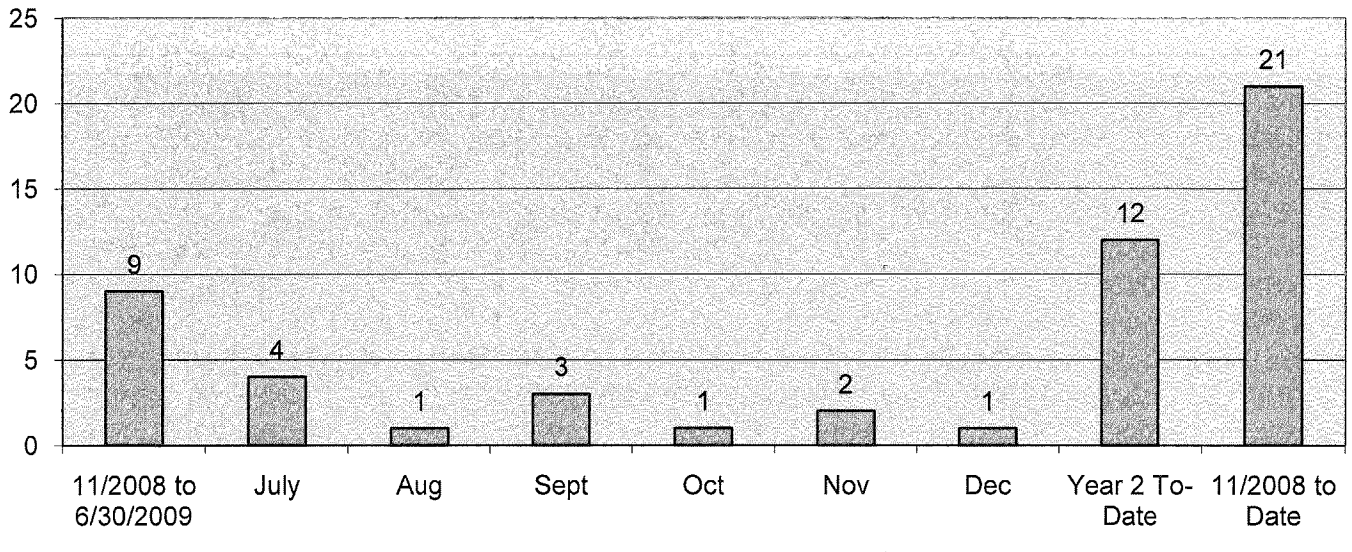
First, HealthShare is doing a much better job at identifying eligible employers. In their first year of operation nearly 24% of all employers contacted were ineligible for the HealthShare product. However after a poor July, the rate of ineligible employers dropped precipitously to almost half (13.18%) the previous year's rate.

Figure 1.1: Percent of Contacted Businesses Not Qualified



The second noteworthy point is that enrollment of firms has increased by a full third, from nine firms in the first seven months of operation to 12 additional firms in the next six months. This change can be seen in Figure 1.2.

Figure 1.2: Number of Businesses Enrolled



The third important point is that in the last six months HealthShare has increased its enrollment by 52% over the previous seven months.

While it is clear that HealthShare will not make its original target enrollment, it is also clear that they are learning to better target their market. What remains unclear is the degree to which the recession versus their value proposition has limited their sales; as their sales have increased at the same time as the recession is subsiding, which is coincident with when HealthShare's marketing efforts would be expected to pay off.

Section 2: Characteristics of HealthShare Enrollees

The makeup of HealthShare enrollees has changed dramatically in the last six months. At the end of June 2009, enrollees were 62% female. At the end of December 2009, that number had reduced to 51%. Likewise, the age distribution of enrollees also changed dramatically between the end of June 2009 and December 2009. As can be seen in Table 2.1, enrollee age became much younger during this period. The bulk of adult enrollees at the end of June 2009 were between 41 and 64 years of age. At the end of December 2009, even without the addition of children, this number had dropped to 45%, almost a 30% reduction. While the December age distribution mirrors the estimated age distribution for Duluth in 2008 (American Community Survey, S0101, Age and Sex), we currently lack data on the age distribution of employed individuals in small firms which would provide a proper comparison. However, from an actuarial view, the younger population is, on average, less expensive and thus a more stable platform for the HealthShare balance sheet.

Table 2.1: HealthShare Enrollees by Age

Age	Jul-09	Dec-09
0 to 12	3.45%	10.91%
13 to 17	0.00%	5.45%
18 to 25	20.69%	14.55%
26 to 40	13.79%	27.27%
41 to 64	62.07%	40.00%
65 +	0.00%	1.82%
	100.00%	100.00%

Although younger, HealthShare enrollees tend to practice healthy lifestyles at the same rate as the general St Louis population, with 50% reporting they never smoked (compared to the Bridge to Health estimate for St. Louis County of 51.3%). However, they have a slightly, but non-significant, higher rate of smoking than the general St. Louis County population (30.4% vs. 20.7%) However one third of those who currently smoke have enrolled in a smoking cessation program. Thirty-seven percent of adult enrollees do not drink alcohol (the same percent reported in the 2005 Bridge to Health Survey for St. Louis County).

Eighty-four percent of HealthShare enrollees participate in the wellness program, for which they receive a 20% discount in their share of the premium. As part of the wellness program enrollees set and track personal goals related to their health status. While individual goals are often very specific, in order to preserve privacy, we present the goals grouped by the general area that the goal addresses. These are shown in table 2.2.

Table 2.2: Wellness Goals and Progress by HealthShare Enrollees

	Goal is:					
Topic Area	**Established**	**Making Progress**	**Not Making Progress**	**Met**	**Not Met**	**Total**
Cardio-Vascular Health		1	1	2		4
Cholesterol Levels	2	1				3
Cholesterol w/in normal range	1					1
Diabetes Health	1	1				2
Mental Health	3	1		1		5
Musculoskeletal Health	2					2
Nutrition/Weight Reduction	2					2
Nutritional Status	3	3				6
Other	3	3				6
Pain Reduction			1			1
Physical Activity	11	6	1	5		23
Pulmonary Health	1					1
Sleep: Increase amount per night				1		1
Tobacco Free		1	1			2
Tobacco: Decrease use	5					5
Weight: Maintain normal Range	1					1
Weight Reduction > 20 lbs	1	2				3
Weight Reduction 0-20 lbs	5	5	1	1		12
Total	41	24	5	10	0	80

Overall, 75% of the enrollees in the wellness program have met with the wellness coach and established personal goals. As can be seen from Table 2.2, over 30% of enrollees who set a goal are making progress toward the goal and another 10% have already met their goal.

However, with respect to preventive services, 92% of women enrolled in HealthShare are up to date with the PAP screening, as are 92% with mammography and 88% with regular breast self-exams as compared to the general St. Louis population, which had rates of 81.9%, 80.9% and 85.9% respectively. Seventy-one percent of HealthShare men are up to date with their prostate exam, compared to 58.3% of St. Louis County men.

Table 2.3 documents the prevalence of chronic conditions for HealthShare enrollees and whether the enrollee has a management plan for the chronic condition. (This table represents only those enrollees enrolled in the wellness plan option of HealthShare). The average number of chronic conditions for those with at least one chronic condition is 1.6. While prevalence data is not available for all the conditions listed in the table, prevalence data for several conditions in the general population of St. Louis County are available from the 2005 Bridge to Health Survey.

These include anxiety, chronic headaches, depression, diabetes and stroke. In each instance the proportion of HealthShare enrollees is less than that reported by the Bridge to Health Survey, but none of the differences are statistically different.

Table 2.3: HealthShare enrollees with Chronic Disease Management Plan			
Chronic Condition	**# of enrollees***	**# with management plan**	**% with management plan**
Anxiety	4	3	75%
Arthritis	7	5	71%
Asthma	3	2	67%
Chronic Headaches	4	1	25%
Chronic Pain	6	2	33%
Depression	9	3	33%
Diabetes Type 2	3	3	100%
Displaced intervertebral Disc	1	1	100%
Grave's Disease	1	1	100%
Hernia	1	0	0%
Hypercholesterolemia	7	6	86%
Hyperlipidemia	1	0	0%
Hypertension	9	8	89%
Hypothyroidism	1	1	100%
Kidney Stones	1	1	100%
Myocarditis	1	0	0%
Osteopenia	1	1	100%
Plantar Fascititis	1	0	0%
Stroke	1	0	0%
Ulcerative Collitis	1	0	0%
* Some enrollees have multiple conditions			

From the health assessment required of all HealthShare enrollees we can calculate several clinically relevant estimates. These include enrollees' BMI, hypertension and cholesterol risk. These are shown, broken down by enrollee's age, in tables 2.4, 2.5 and 2.6 respectively. Again, comparative data are not available for either hypertension or cholesterol, which both require measurement from a medical professional. However, the Bridge to Health Survey, once again, does provide a bench mark for BMI. We find that HealthShare enrollees are significantly heavier than the general population of St. Louis County, with 71.4% of enrollees overweight or obese while only 52.9% of St. Louis County is reported as overweight or obese.

Table 2.4: HealthShare Enrollee's BMI					
Age	**Underweight**	**Normal**	**Overweight**	**Obese**	**Total**
18-24	1	2	3	0	6
25-34	0	3	5	1	9
35-44	0	0	1	2	3
45-54	0	1	1	0	2
55+	0	1	4	3	8
%	3.6%	25.0%	50.0%	21.4%	100.0%

Table 2.5: HealthShare Enrollee's Hypertension Risk				
Age	Normal	Pre-Hypertension	Hypertension stage 1	Total
0 - 17	6	0	0	6
18-24	2	3	0	5
25-34	11	3	0	14
35-44	4	2	0	6
45-54	1	2	2	5
55+	2	10	3	15
%	51.0%	39.2%	9.8%	100.0%

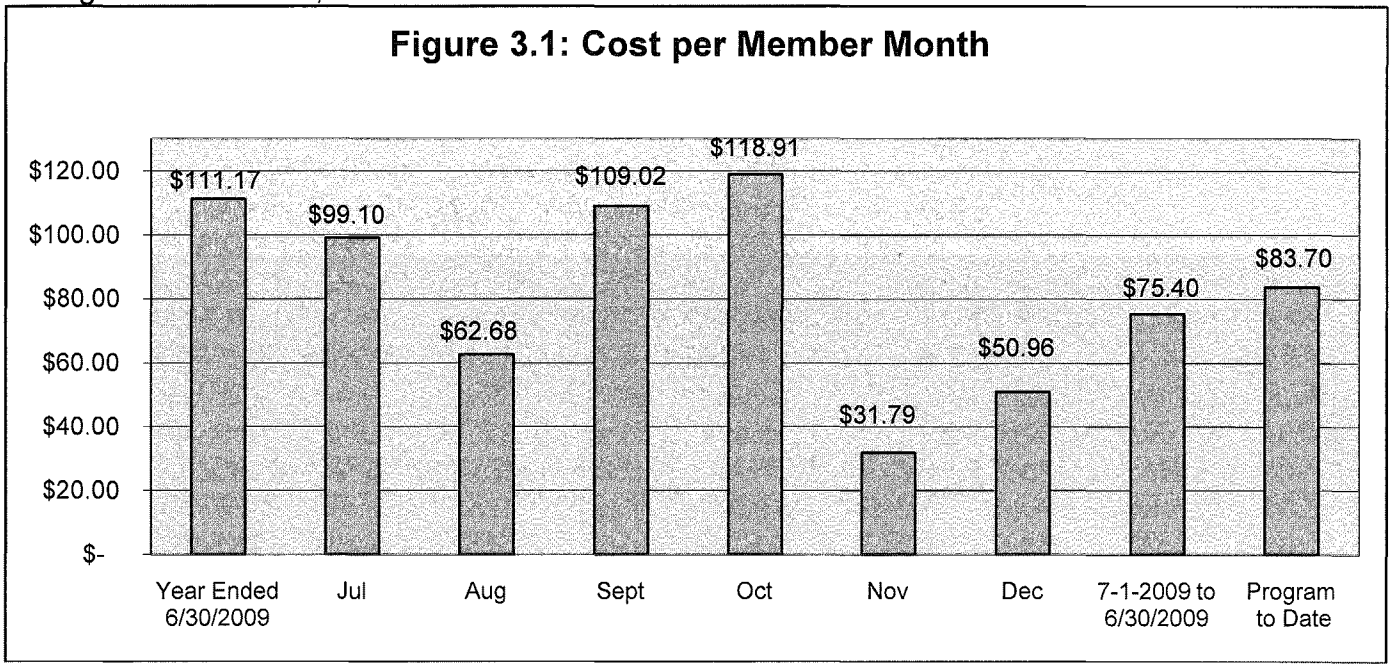
Table 2.6: HealthShare Enrollee's Cholesterol Level			
Age	Desirable	High	Total
35-44	1	0	1
45-54	1	1	2
55+	3	1	4
%	71.4%	28.6%	100.0%

Section 3: Program Costs

Data for the cost analysis came form two sources. The first was the master enrollment database maintained by HealthShare (2010 HealthShare member data.xls), which contains data for 51 of the 56 HealthShare members. The second was data provided by the HealthShare CFO (AC 102402 HS 2010 12-31-09.xls).

Figure 3.1 shows the medical cost per member per month for the six month period July 1, 2009 through December 31, 2009.

Figure 3.1: Cost per Member Month



These costs are further broken down into medical and pharmacy cost in Table 3.1.

Table 3.1: HealthShare Cost Per Member Per Month									
	Year Ended 6/30/2009	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**7-1-2009 to 6/30/2009**	**Program to Date**
Claims Expense									
Medical	$7,754	$2,725	$2,006	$4,222	$5,241	$1,327	$2,443	$17,964	$25,718
Pharmacy	$917	$149	$125	$248	$229	$326	$411	$1,488	$2,405
Total Claims Expense	$8,671	$2,874	$2,131	$4,470	$5,470	$1,653	$2,854	$19,452	$28,123
Member Months	78	29	34	41	46	52	56	258	336
Cost per Member Month	**$111**	**$99**	**$63**	**$109**	**$119**	**$32**	**$51**	**$75**	**$84**

Using the HealthShare member data, we find that of the 55 enrollees documented in this file nearly four in five enrolled in HealthShare's wellness program (see Figures 3.2 and 3.3)

Table 3.2: Enrollee relationship				
	Relationship to subscriber			
HealthShare Program	Self	Dependent	Child	Total
Standard	6	3	2	11
Wellness	32	6	6	44

Table 3.3: Enrollee relationship (%)				
	Relationship to subscriber			
HealthShare Program	Self	Dependent	Child	Total
Standard	10.91%	5.45%	3.64%	20.00%
Wellness	58.18%	10.91%	10.91%	80.00%
Total	69.09%	16.36%	14.55%	100.00%

The monthly premiums for enrollees are given in Table 3.3.

Table 3.4: Monthly Premium			
	Relationship to subscriber		
HealthShare Program	Self*	Dependent	Child
Standard	53	127	84
Wellness	67	113	84
* in addition the employer contribute $60 per month			

Combining the data on enrollment and premium, we calculate premium revenue of $29,439 based on 257 member months between July 1, 2009 and December 31, 2009. While we cannot at this time compute a medical cost ratio, we can estimate the ration of claims paid per member month (from Table 3.1) and the average paid premium from the member data (which is $111 per month).

Using these data, we estimate medical cost ratio of 66.08%. This estimate is necessarily low as no IBNR has been included in the calculation and includes only the payment of medical expenses for inpatient and outpatient services and pharmacy. Other eligible medical expenses have not been included in this calculation. But, most importantly, an additional multiple-day hospital stay from just one enrollee would likely raise this ratio to above 1.0.

SUMMARY

In summary, HealthShare has increased their pace of enrollment and developed a more effective marketing and sales strategy that have resulted in both more sales and better selection of potential clients. In addition, HealthShare enrollees tend to be fairly young, relatively healthy, actively involved in prevention efforts and, through the wellness program, monitoring and addressing poor health care practices.

HealthShare is currently, based upon estimates of medical expenses and premium revenues, in a liquid position that should allow them to continue recruiting employers and enrolling new members. However, while current claims for services have been relatively low, shocks to HealthShare's balance sheet should be expected. With such a small enrollee base adequate reserves and/or re-insurance will undoubtedly be drawn upon in future months.

Analysis on enrollees who have aggregate medical claims over $5,000 per year

As of Dec. 31, 2009, there was just one enrollee with a medical claim exceeding $5,000. The claim was $7,053.05 to cover health care services related to lower back problems.

Family Income

HealthShare does not require enrollees to submit documentation of household income. The data listed below is from 73% the members enrolled as of 12/31/09 who voluntarialy completed a screening to determine whether s/he would be potentially eligible for a public health program.

Annual Income	Number
Less than $10,000	0
$10,000-19,999	15
$20,000 – 29,999	15
$30,000 – 39,999	6
$40,000 – 49,999	1
$50,000 – 59,9999	2
$60,000 – 69,9999	0
Over $70,0000	1
Total	**40**

Number of Enrollee Referred for Public Programs

A total of 22 people were referred the Lake Superior Communtiy Health Center, Health Care Access Office for assistance to enroll in some type of public program.

Number of employers and employees who have been denied access to the program

No business or employee who met enrollment criteria for HealthShare was denied access to the program. [Enrollment criteria is included in the Employee Handbook which is included as Appendix A of this report.]

HealthShare

Health and Program Outcomes

With Performance Measurements

The legislation creating the Community-based Health Coverage Program [Minn. Stat 62Q.80 subd1(b)] includes three required outcomes which are listed as the items 1-3 in the table below. Other items listed are those in which the project has added.

Outcome	Measurement	Baseline/Yr	Anticipated Outcome/Yr	Outcomes 12/31/09
1. Reduction in uncompensated care by participating providers	Dollars of charity care at participating hospitals (Not readily available from clinics or other providers)	TBD 2007 data from MDH/MHA	5%/ reduction in charity care by Yr 3 (if there are no major changes in reimbursement structures or group market coverage)	Not Available
2. Increase in delivery of preventive services	Preventative services received or education programs attended at members at time of enrollment compared with services after 1 yr with HealthShare	Each member will report at time of enrollment	75% of members up-to-date on recommended preventive screenings/services by Yr 3 (Vaccinations, mammogram, pap. prostate, blood pressure, and cholesterol screening, children's developmental screening)	Baseline Screenings up-to-date: Mammogram: 92.0% Pap: 92.0% Prostate: 71.4%
3. Health improvement for enrollees with chronic conditions. Target conditions are: Diabetes Hypertension	 Diabetes: A1c levels, LDL level, blood pressure Hypertension: Blood pressure	Each member will complete a chronic disease checklist. Members with chronic diseases will report their baseline date on their condition to the health advisor.	100% of members complete chronic disease checklist Those with diabetes: • 90% have A1c tested every 6 months • 75% have Alc at 7 or less • 90% have LDL levels tested annually • 75% have LDL at or less than 100mg/dl • 95% have a diabetes management plan Those with hypertension: • 95% have their blood pressure checked annually • 80% have blood pressure within normal range (140/90 or lower) • 95% of those with elevated BP (140/80 or higher) have a hypertension management plan	97.4% of adult wellness members completed chronic disease checklist 3 wellness members with diabetes 100% have a diabetes management plan 69.9% of adult wellness members had BP checked within the 12 months. 81.8% had BP in normal range 88.9% of members with hypertension have a management plan

Outcome	Measurement	Baseline/Yr	Anticipated Outcome/Yr	Outcomes 12/31/09
4. Reduction in smoking.	Self-report of current smoking behavior	Each member will report at time of enrollment (Those enrolled in Wellness Option only)	• 50% of members who smoke attend smoking cessation class • 10% of enrollees report that they have quit smoking by Yr 3	30.4% of members currently smoke. 33% of wellness members who smoke are enrolled in QuitPlan program
5. Increase in the number of enrollees at normal weight.	BMI (Body Mass Index) > 30 is overweight/obese	Each member will report at time of enrollment(Those enrolled in Wellness Option only)	• 50% of members have weight within normal range • 75% of those overweight/obese have weight management plan	30.2% of members have weight within the normal range; 39.5% are overweight; 27.9% are obese. 45% of those overweight/obese have weight loss or physical activity goals
6. Wellness Option enrollees achieve measurable progress on their health goals	Measures determined by member and health advisor	Baseline on each health goal determined by member and health advisor	75% of the members will make progress on their individual health goals	83.6% of members are enrolled in the Wellness Option. All wellness members have set annual health goals. 42.5% have are making progress on or have met goals to date. Baselines established. *Listing of member goals on attached page.

Comments related to 62Q.80 Subd. 13(b)7

7) a comparison of employer-subsidized health coverage provided in a comparable geographic area to the designated community-based geographic area served by the program, including, to the extent available:

(i) the difference in the number of employers with 50 or fewer employees offering employer-subsidized health coverage;

(ii) the difference in uncompensated care being provided in each area; and

(iii) a comparison of health care outcomes and measurements established by the initiative; and

(iv) any other information requested by the commissioner of health or commerce.

Summary of Communication between Michael D. Finch, Program Evaluator and Scott Leitz, Assistant Commissioner of Health, October 20, 2008

The evaluation criteria for this demonstration were specified in 62Q.80 Subd. 13(b). When we [Finch & King] reviewed these it became obvious that no meaningful response could be provided to 13(b).7. This is because adequate secondary data to support this section do not exist and funds to collect primary data were neither allocated nor available.

In 2008 when the demonstrated was just getting underway, it was recognized that this would likely be the case throughout the period of the demonstrated. In response an inquiry was sent to Scott Leitz, Assistant Commissioner of Health, and previously head of the Health Economics Program, stating our concerns.

His reply from Oct. 20, 2008 is below:

> I did have a chance to talk to folks internally about this. Mark Schoenbaum, who I am cc:ing on this email and who directs our Office of Rural Health and Primary Care, is the lead person in our agency on the grant we put through to Generations on this.
>
> It seems like the main thrust of the evaluation component here was to see whether or not this thing actually increased employer-based coverage, and the number of people with coverage generally. Some of this is probably doable through data collected by Generations and through some of the existing data tools out there (like MDH's uninsured survey, etc). I'm guessing a number of these questions are simply not addressable at this point, primarily due to data limitations. So, I guess our guidance would be to do the best possible to address the thrust of the questions that the legislature had on this, but don't feel slavishly devoted to trying to specifically answer questions where data simply doesn't exist or where it would be prohibitively expensive to collect. Sounds like a comparison and quality

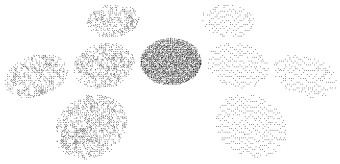
measures simply can't be done at this point, and if that's the case, again, just do whatever is possible with existing information.

Scott Leitz
Assistant Commissioner
Minnesota Department of Health

To fulfill the spirit of this communication we recently reviewed available data such as the Employee Benefits Survey conducted by the Minnesota Department of Employment and Economic Development, but the last survey was conducted in 2005. The Small Group and Individual Market Survey conducted by the Minnesota Department of Health was last preformed in 2006. Unfortunately, the Department's latest Health Insurance Survey (2009) is not publicly available at this time and the Department's Health Economics Program as, to this date, not published data on geographic areas of eth uninsured likewise independent community health surveys were also out dated. The last Bridge to Health survey was conducted in 2005 and the last Shape survey was conducted in 2006.

Again, we find that we are unable to provide reasonable valid data to address the points in 62Q.80 Subd. 13(b).7.

Michael D. Finch, PhD
Finch & King, Inc.



HealthShare™

A HEALTH COVERAGE PROGRAM

PROGRAM HANDBOOK

Important Notice:

To the fullest extent permitted by law, HealthShare reserves the sole right to do any of the following at any time: (a) terminate the HealthShare program in whole or in part; (b) change, add or delete any or all of its policies and rules, including but not limited to those pertaining in any way to member or employer eligibility, coverage, exclusions from coverage, termination of coverage, covered and non-covered benefits, claims, billing, benefit levels and maximums, co-payments, deductibles, subrogation, coordination of benefits, program costs or changes, grievances, protocols, pre-authorization, privacy, referrals, assignment of benefits and/or participating providers; (c) change its participating providers, including additions and deletions to those participating; and (d) resolve any conflict between different terms of this Handbook and/or between any of the terms of this Handbook and those of any other HealthShare document or policy. HealthShare will provide advance notice of such terminations or changes when and to the extent such notice is required by law but does not guarantee that any notice not required by law will be given, and does not guarantee that any such termination or change will not be made. This program is not an insurance product and, as such, is exempt from state regulation of insurance products.

HealthShare

HEALTH COVERAGE FOR SMALL BUSINESS AND THEIR EMPLOYEES

Table of Contents

Welcome to HealthShare

Welcome to HealthShare. HealthShare is a community-based health coverage program designed to keep you healthy and provide you health services from local health care organizations when you need them. The program is available through a partnership involving local health care providers, Generations Health Care Initiatives, and the State of Minnesota.

There are many unique features to HealthShare. This Member Handbook explains the significant aspects of the program. Please read the Handbook carefully and call the HealthShare Member Services staff if you have *any* questions, (218) 336-5711.

We look forward to serving you and helping you achieve good health.

Sincerely,

Your HealthShare Staff

About HealthShare

In 2007, Minnesota enacted legislation which allowed for creation of a demonstration project in northeastern Minnesota that would expand access to health care to uninsured people employed by small businesses. The project is based on a national model called a "multiple share" model. This program, HealthShare, offers affordable coverage to a population most likely to be uninsured, those working in small businesses (50 employees or less).[1]

HealthShare is a community-based health coverage program, not health insurance. It actively involves employers, employees, local health care providers, community organizations, and you, the member. Things are done differently with HealthShare because the emphasis is on health care, not sick care. Health improvement, effective use of health services and community resources, coordination of care, education, and member responsibility are key aspects of the program.

HealthShare requires members to establish a trusting relationship with a doctor or health care provider so that this person knows you and can work with you to maintain your maximum health. Through HealthShare you have access to a Care Manager and other resources that help you address your health concerns and attain your health goals.

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[1] Source: - Minnesota Department of Health, Health Economics Program (2006), *Health Insurance Coverage in Minnesota: Trends From 2001 to 2004*

HealthShare's Mission & Vision

HealthShare's ***mission*** is to demonstrate that a well-coordinated, cost-effective program can provide coverage for basic health care and wellness services for uninsured employees of small businesses.

Our ***vision*** is to demonstrate that a community-based health care coverage model is a viable means for expanding health coverage to employees of small businesses who were previously uninsured, increase the number of people employed in small businesses who have health coverage, engage members in effectively managing their health care and improving their overall health status.

HealthShare's Call to Action

The rise in health care costs is a problem affecting every facet of our community. The problem is complex and cannot be solved in one day, by one person. It takes a village to solve the problem, or in our case, a community making a conscious effort to improve our health. At the heart of the community are individuals. HealthShare recognizes this in making the individual member a key part of the solution to affordable health improvement. HealthShare would like to become your partner in health.

The Role of HealthShare

Our role is to provide affordable access to health services and to educate its members and business partners on the importance of maintaining good health.

The Role of the Individual Member

The member's role is to seek optimal health through lifestyle choices, including increased physical activity, healthy nutrition, receiving preventative physical exams/tests, and stop smoking.

The Role of Business Partners

It's the business partners' role to promote healthy work environments, physical activity, no-smoking policies, healthy snack facilities, and to provide health promotions for customers and employees.

The Role of the Community

The community is a partner in making HealthShare available to local small businesses, their employees and families. The community is encouraged to provide inexpensive and accessible ways for citizens to increase physical activity (safe sidewalks, accessible parks and bike paths, etc.), and to provide free or inexpensive health education classes to continue to promote health and wellness.

ELIGIBILITY

Business/Employer Eligibility

For a business to participate in HealthShare, it must meet all of the following criteria both at the time of application and, except as specified otherwise below, throughout the entire period of its participation:

- The business must qualify as a business according to IRS definition.
- The business must employ at least one but no more than 50 employees at the time of initial enrollment in the program. Employee count is based on weekly payroll hours. 2,000 hours or less per week qualifies as 50 or less employees.
- The corporate office of the business must be located in an area where HealthShare is offered.
- The business must have one or more W-2 employees.
- The median wage of all Employees within the specified Designated Employee Group at the date of application must meet the current wage qualifier established by HealthShare, currently $12.50 per hour.
- The business must offer coverage to all uninsured Employees who work and are paid for an average of 15.5 hours or more per week.
- The business does not offer health coverage to one or more of its Designated Employee Group(s) at the time of application and did not offer it to that Designated Employee Group during the 12 months preceding the date of application. Full-time and part-time employees are considered separate Designated Employee Groups for this test. Or, the business does offer health coverage to one or more of its Designated Employee Groups, but contributes less than 50% to the employees' monthly premium.
- Dependent coverage must be offered to all uninsured dependents of all members of the Designated Employee Group.
- The employer must pay at least $60 of the monthly cost of the HealthShare program for its employees. Employer is ***not*** required to contribute to the dependent monthly cost. The business may opt to pay the entire share if they wish.
- The business can have a traditional health insurance plan and still offer HealthShare. The uninsured employees that don't qualify for an existing plan could be eligible for HealthShare. However, an employee cannot drop existing health insurance in order to enroll in HealthShare.
- The employer must execute the HealthShare Employer Contract and comply with its terms.
- The employer must notify HealthShare immediately upon discovering that the employer fails to meet any of the employer eligibility criteria or that any employee fails to meet any of the employee eligibility criteria.
- HealthShare may formally review a business' eligibility for continued program participation at least annually and may terminate a business' participation at any time that it fails to meet any of the employer eligibility criteria.

Employee Eligibility

For an individual employee to be eligible to participate in HealthShare, he or she must meet all of the following criteria both at the time of his/her application and, except as specified otherwise below, throughout the entire period of his/her participation:

- Be an active, bona fide, paid Employee working an average of 15.5 hours per week minimum, to whom the employer issues a W-2, and not an independent contractor, seasonal, temporary worker or retiree.
- Have been continuously and actively employed as an Employee for the duration of time set forth by the employer as the initial wait period. Wait period cannot exceed 13 weeks.
- Is not eligible to participate in, and is not currently covered, either directly or as a dependent, under any type of federal, state or business-sponsored ongoing health insurance, health benefit plan or program of health benefits, including but not limited to Medicare, Medical Assistance, Veterans Health Care, Native American Health Care or any ongoing employer-or association-sponsored health benefit program.
- HealthShare may formally review an employee's eligibility for continued program participation at least annually and may terminate the employee's participation at any time that he/she fails to meet any of the employee eligibility criteria.
- The employee must notify HealthShare immediately upon discovering that he/she fails to meet any of the employee eligibility criteria.

Special Circumstances

- Pregnancy is only a covered benefit with HealthShare if the member is not eligible for Medical Assistance. HealthShare staff will screen for Medical Assistance eligibility and facilitate enrollment in the program.
- Medicare eligible members are not eligible for HealthShare; this includes Medicare for a disability, upon turning age 65 and/or ESRD (End Stage Renal Disease).
- If the employee becomes ineligible for HealthShare due to change in employment status, the enrolled dependents are no longer eligible.

Members' Rights & Responsibilities:

As a member of HealthShare (either directly or as a covered dependent) you have many rights. They include the right to privacy, to receive prompt medical care and to have the information you need to participate in decisions about your treatment.

You also have responsibilities. Your responsibilities include, but are not necessarily limited to the following:

- You must read and agree to be bound by the HealthShare Handbook. If you have any questions or do not understand any aspects of the plan, contact HealthShare. You must comply with the requirements described or referenced in the Program Handbook.

- You must coordinate all medical services through your Primary Care Clinic and/or HealthShare. It is your responsibility to obtain a referral or prior authorization for services requiring one.

- Each HealthShare member must show his/her individual HealthShare Member Card to the provider when medical services are received. Each HealthShare member has a card and unique member number.

- You must pay all co-payments when medical services are provided.

- You must provide accurate information needed for proper medical care.

- You must tell us if you become eligible for health benefits from any other program or discover that you no longer meet any of the employee eligibility criteria.

- You must tell us if your address and/or phone number changes.

- You must tell us if your member card is lost or stolen.

- You must tell us if you have applied for disability or Workers' Compensation benefits, even if you have not received a determination or have been denied.

- You must tell us if a third party is, or may be, responsible for some or all of your health care costs (examples: Another person, a business, your employer or an auto, homeowners or liability insurance company), or if you file or settle a lawsuit regarding personal injuries or health care costs or benefits or receive a payment, judgment, settlement or other award for personal injuries or health care costs or benefits.

- You must sign any document, and take any other action, reasonably requested by HealthShare to permit HealthShare or obtain reimbursement from a responsible third party for health care costs or benefits HealthShare has provided on your behalf.

Active Participation in Your Health Care

You must be committed to being an active participant in your own health care. The goal of HealthShare is to provide affordable, appropriate health care to improve your long-term health. HealthShare encourages preventative care and encourages you to receive tests that are recommended for persons of similar age to prevent potentially serious medical problems before they occur.

Chronic Disease Management

If a member is diagnosed with a persistent or chronic condition, the member agrees to comply with a treatment plan and work with physicians in the appropriate course of treatment. If a member does not follow the recommended protocols, treatments or

recommendations, or make lifestyle changes that will improve health, the services received may not be covered and the member would be financially responsible for them.

Employers' Responsibilities

Employers have responsibilities to their employees and to HealthShare if they choose to take advantage of the HealthShare Program. Those responsibilities include, but are not necessarily limited to the following:

- Provide a workplace environment that supports the Mission and Vision of HealthShare.
- Understand and abide by the terms and conditions of the Employer Contract.
- Pay monthly charges for the HealthShare program on a timely basis. Coverage may be terminated for late, partial, or nonpayment of charges.
- Submit enrollment and termination forms on a timely basis.
- Pay the cost of coverage until HealthShare receives a termination notice.
- Make all new employees who are possibly eligible aware of the HealthShare program and assist them in contacting HealthShare for an eligibility determination.
- Provide all required information for the completion of any employer or employee eligibility review on a timely and accurate basis.
- Obtain and maintain in force all Workers' Compensation insurance or alternative coverage required by law and provide evidence of it to HealthShare at the time of application for participation and thereafter upon request by HealthShare.
- Notify HealthShare immediately upon discovering that the employer or any of its employees fails to meet any applicable employer or employee eligibility criteria.

Member Enrollment

The member enrollment process includes an in-person meeting by a HealthShare representative with the member to explain the important features and benefits of the program. To enroll in HealthShare, you must complete the following:

- Health Coverage Survey
- MAPSng Form (Screens for other possible program eligibility)
- Enrollment Form (Select Wellness or Standard Option)

- Select a Primary Care Clinic (PCC) participating with HealthShare
- Service Area Acknowledgement Form
- Health Risk Appraisal
- Employee Checklist
- Meet with a HealthShare Representative

Enrollment Options

HealthShare gives you the choice of two benefit programs: **Wellness Option** and the **Standard Option**. You must specifically choose to join the Wellness Option or you will be assigned to the Standard Option by default.

Wellness Option

The Wellness Option is designed to help you take careful, managed steps toward improving your long-term health. You will also save money along the way, as Wellness Option participants pay a lower monthly premium and have lower co-payments for the services they receive. The Wellness Option requires a commitment on your part, but you are not alone. Your Care Manager and HealthShare staff will provide you with the help and encouragement for you to be successful.

Wellness Option Participants Have the Following Responsibilities:

- You and all of your participating family members must complete a Health Risk Appraisal.
- You must meet with your Care Manager within one month of signing up for the Wellness Option.
- You and your Care Manager will develop a Health Action Plan to address any current health issues or risks.
- Attend two health classes or participate in two health related acitvities within 12 months of enrollment.
- If you smoke, you will need to attend and complete a recommended smoking cessation program.
- If you have a persistent or chronic health condition such as diabetes, high blood pressure or obesity, you will need to meet with a Care Manager and participate in educational classes related to your chronic health condition.
- If you do not meet the conditions and requirements of the Wellness Option, you will be transferred to the Standard Plan and will no longer receive the monthly

rate and lower co-pays of the Wellness Option. You may change plans during open enrollment periods designated by HealthShare but must remain in your chosen plan for at least six months.

- Members are responsible for scheduling their Care Manager Meeting (must be completed within 30 days of enrollment) and classes. Call 218-336-5706 with any questions regarding the Wellness Option requirements or to schedule a Care Manager meeting.

Standard Option

The Standard Option does not require the members to complete the requirements listed above. **However, members enrolling in the Standard Option who have a chronic medical condition are required to meet with a HealthShare Care Manager.** It has higher monthly premiums and higher co-payments than the Wellness Option. If you do not make a timely choice to participate in the Wellness Option, you will be assigned to the Standard Option. You may transfer to the Wellness Option during an open enrollment period after at least six months in the Standard Option.

Accessing Care

How to Access Preventative, Routine & Specialty Care

- You must choose a Primary Care Clinic (PCC) and establish a provider-patient relationship with a doctor, physician's assistant, or nurse practitioner specializing in family practice, general practice, internal medicine, or pediatrics. Any other type of provider is considered a specialist and is subject to referral guidelines and specialist copay rates.

- In general, if you need medical care, call your PCC first. If you feel your condition is an emergency, seek immediate medical attention.

- Health care service referrals must be referred through your PCC. This includes referrals to specialists and hospitals. Your PCC coordinates all of your health care needs.

- You need to tell HealthShare Member Services if you change your PCC. You may change your PCC only once a year. Any health care services provided in a clinic other than your PCC, ***or within your PCC by a specialist***, will be considered specialist care and subject to a higher co-payment and referral guidelines.

- Your PCC will refer you to a specialist if necessary or order tests or services that may require prior authorization. To be sure that the specialty care, tests or other services requiring prior authorization is covered, ***it is your responsibility to call HealthShare and obtain a referral or prior authorization prior to visiting the specialist or completing the tests/services***. The Referral and/or prior authorization will be used to help understand your health needs and to better

coordinate your care. HealthShare Care Managers will review the Referral and issue an Authorization for the requested services if appropriate. If you do not obtain a Referral or prior authorization from HealthShare for providers or services that require one, you will be responsible for any unpaid charges for the unauthorized services.

- Refer to the "Medical Services Requiring Notification" section of this Handbook if you're unsure if the provider, test, or service requires a referral or prior authorization. You may also contact HealthShare directly at 336-5711.

Urgent & Emergency Care

How to Access Urgent Care & Emergency Care

Urgent Care Centers

If you have an urgent medical problem that is not an emergency, but needs timely attention, call your PCC first. Your PCC knows you and your medical history and is the best person to help you with your medical needs. If you can't reach your PCC after making reasonable attempts, and you require urgent care, go to one of the participating urgent care centers. A list of participating urgent care centers is listed in the Handbook.

Be sure to call your PCC after receiving care at the urgent care center so that your PCC may coordinate any follow-up care if it is needed.

Emergency Care

An "Emergency Medical Condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) serious jeopardy to the health the individual or, in the case of a pregnant woman, to the health of the woman or her unborn child; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

If you have any questions as to whether or not you should go to the emergency department, call your PCC or, if after hours, your PCC's on-call physician. Be sure to call your PCC within 48 hours of receiving care at the emergency room so that your PCC may coordinate any follow-up care that is needed.

Outpatient & Inpatient Care

How to Access Outpatient & Inpatient Hospital Care

Your PCC coordinates all of your health care needs, including any hospital testing, surgical procedures or inpatient admissions. You must contact HealthShare if your PCC orders any surgical procedure, or certain diagnostic tests performed at a hospital. This Handbook includes a complete listing of services that require prior authorization and their requirements. **You are responsible for obtaining the Referral and contacting HealthShare for the Prior Authorization.**

Health Care Administration

HealthShare provides health administration services for all members and will work closely with you to help you manage any significant health problems. The Care Manager is here to assist the member and providers regarding medical services and may be reached at 218-336-5706.

The Care Manager will help you with the following:

- Communicate with your PCC and providers to coordinate your health care services.
- Review and manage any Referrals and Prior Authorizations for services requested from you or your PCC.
- Work closely with you if you are diagnosed with a chronic disease, such as asthma, diabetes or if you have an identified health risk.
- Assist you in the completion of the Protocols prior to receiving certain medical services.
- Monitor your progress while hospitalized and assist your physician to identify potential discharge planning needs.
- Identify and enroll in health classes that would be valuable to you.
- Conduct home visits to help your PCC identify potential health risks associated with environments or behaviors.
- Find other community resources to help you pay for any medical services not covered by HealthShare.
- For women, coordinate mammogram and cervical cancer screenings.

Medical Services – No Notification Required

The following services do not require the member or provider to notify HealthShare.
Co-pay is a per occurrence member responsibility.

Service	Wellness Option	Standard Option
Primary Care Visit (Family or General Practitioner, Internal Medicine, or Pediatrician)	$10 co-pay	$20 co-pay
Urgent Care Visit	$30 co-pay	$40 co-pay
Outpatient Labs	No co-pay	No co-pay
Outpatient X-Rays including screening mammograms if patient is 40 years old or older	25% co-pay $400 Max co-pay	30% co-pay $500 Max co-pay
Emergency Room	$75 co-pay	$100 co-pay
Ambulance	30% co-pay	40% co-pay
Blood Products	$20 co-pay per unit	$20 co-pay per unit
Supplies—Under $100. If over $100 requires preauthorization	Member pays first $100 per purchase, then a 25% co-pay	Member pays first $100 per purchase, then a 35% co-pay
Durable Medical Equipment under $100 (If over $100 requires pre-authorization)	25% co-pay (HealthShare maximum payment is $500 per occurrence. Member is responsible for amount over $500)	35% co-pay (HealthShare maximum payment is $400 per occurrence. Member is responsible for amount over $400)
Pharmacy Yearly Maximum – Refer to the Member Formulary Grid. Some RXs do require prior authorization	$3000 per year paid by HealthShare (Member is responsible for amount over $3000)	$2,000 per year paid by HealthShare (Member is responsible for amount over $2000)
Generic Medications	$7 co-pay	$12 co-pay
Formulary Brand Medications	50% co-pay	50% co-pay
Non-Formulary Brand Medications	60% co-pay	60% co-pay

Lifetime Maximum: $200,000. 5 year Maximum: $100,000

Medical Services Requiring Notification

Medical Service	Referral Required	Prior Authorization Required	Subject To HealthShare Protocol	Treatment Plan Required	Wellness Option Member Co-pay (Co-pay is a per occurrence member responsibility)	Standard Option Member Co-pay (Co-pay is a per occurrence member responsibility)
Specialist (Non-PCP) office visit(s)	X				$30 co-pay	$40 co-pay
Vision Screening- Eye Injury or Medical Condition	X	X			$20 co-pay (Optometrist) $30 co-pay (Ophthalmologist)	$30 co-pay (Optometrist) $40 co-pay (Ophthalmologist)
Prenatal & pregnancy care with a specialist. (If not Medicaid eligible)	X	X			$225 Maximum co-pay for entire pregnancy	$350 Maximum co-pay for entire pregnancy
Screening Mammogram if patient is less than 40 years old	X	X			25% $400 Max co-pay	30% $500 Max co-pay
CT Scan	X	X	X		25% $400 Max co-pay	30% $500 Max co-pay
MRI	X	X	X		25% $400 Max co-pay	30% $500 Max co-pay
Bone Density (Age 50+)					25% $400 Max co-pay	30% $500 Max co-pay
Bone Density (Under 50)	X	X	X		25% $400 Max co-pay	30% $500 Max co-pay
Apnea Testing	X	X	X		50% co-pay	50% co-pay
Holter Monitor–24 Hour	X	X			25% $400 Max co-pay	30% $500 Max co-pay
Needle Biopsy (Breast Only)	X	X			25% $400 Max co-pay	30% $500 Max co-pay
Pulmonary Function Testing	X	X	X		25% $400 Max co-pay	30% $500 Max co-pay
Echo Testing / Ultrasounds	X	X			25% $400 Max co-pay	30% $500 Max co-pay
Colonoscopy	X	X			25% $400 Max co-pay	30% $500 Max co-pay
Gastroscopy	X	X	X		25% $400 Max co-pay	30% $500 Max co-pay
Bronchoscopy	X	X	X		25% $400 Max co-pay	30% $500 Max co-pay
Angiography	X	X			25% $400 Max co-pay	30% $500 Max co-pay
Any Other Outpatient Diagnostic Testing	X	X			25% $400 Max co-pay	30% $500 Max co-pay
Stress Test—Outpatient Hospital	X	X			25% $400 Max co-pay	30% $500 Max co-pay

Medical Service	Referral Required	Prior Authorization Required	Subject To HealthShare Protocol	Treatment Plan Required	Wellness Option Member Co-pay (Co-pay is a per occurrence member responsibility)	Standard Option Member Co-pay (Co-pay is a per occurrence member responsibility)
Stress Test -Clinic	X	X			$30 co-pay	$40 co-pay
Allergy Testing	X	X	X	X	$30 co-pay	$40 co-pay
Wound Care	X	X		X	25% $400 Max co-pay	30% $500 Max co-pay
Pain Clinic	X	X	X	X	50% co-pay	50% co-pay
Chemotherapy & Radiation Therapy—Hospital Outpatient	X	X		X	$25 co-pay	$30 co-pay
Chemotherapy & Radiation Therapy—Clinic Setting	X	X		X	$25 co-pay	$30 co-pay
Outpatient Surgery	X	X	X		25% $400 Max co-pay	30% $500 Max co-pay
Inpatient Hospitalization	X	X	X		15% $400 Max co-pay	25% $500 Max co-pay
Durable Medical Equipment, Orthotics & Devices—Over $100	X	X			25% co-pay (HealthShare maximum payment is $500 per occurrence. Member is responsible for amount over $500)	35% co-pay (HealthShare maximum payment is $400 per occurrence. Member is responsible for amount over $400)
Home Care	X	X			$20 Co-pay	$30 Co-pay
Respiratory Therapy	X	X		X	25% $400 Max co-pay	30% $500 Max co-pay
Cardiac Rehabilitation	X	X		X	25% $400 Max co-pay	30% $500 Max co-pay
Physical, Occupational & Speech Therapy	X	X			$20 Co-pay 20 visits max per year	$30 Co-pay 20 visits max per year
Outpatient Behavioral Health	X	X	X After 3 visits		$20 Co-pay 20 visits max per year	$30 Co-pay 20 visits max per year

Exclusions & Non-Covered Services

This section describes services, supplies and medications that are not covered services under HealthShare. Any and all costs related to the services, supplies and medications listed below will not be paid by HealthShare and will be your responsibility to pay in full.

1. Any medical services performed or received from a health care organization that is not a participating provider for HealthShare.

2. Prescription drugs or supplies not obtained from a participating pharmacy.

3. Medical services, supplies or medications of any type for treatment of any injury or condition that occurred or arose out of the member's operation or occupancy of, collision or contact with, or fall or descent from, any motorized or powered vehicle or conveyance used for purposes of ground or air transportation or sport, whether powered by a gasoline or other fuel-burning engine or by battery or electric motor or combination or hybrid thereof, or by any means other than purely human effort, regardless of whether such vehicle or conveyance is or is not covered by or subject to the Minnesota No-Fault Law or successor law, and including, but not limited to, any automobile, truck, tractor, snowmobile, motorized scooter, personal watercraft, dirt bike, motorcycle, all-terrain vehicle (ATV), off-road vehicle (ORV), dune buggy, boat, motor home, recreational vehicle, airplane, helicopter, glider, parasail or paraglider. This exclusion does not apply to medical services, supplies or medications of any type for treatment of any injury or condition that occurred or arose out of member's status as a fare-paying passenger on a licensed, commercial, regularly scheduled non-military aircraft.

4. Medical services, supplies or medications which, as determined by HealthShare, are experimental, investigational, or not medically necessary, or which are received after the member ceases treatment against medical advice.

5. Medical services, supplies or medications received from or paid for by any tribal, federal, state or local government plan or program, including but not limited to, Medicaid/Medical Assistance, Medicare, Breast and Cervical Cancer Program, Tri Care, Railroad Retirement, and tribal medical programs.

6. Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem, or medical services, supplies or medications for treatment of any complication resulting from such surgery or surgical procedure. This exclusion does not apply to reconstructive surgery to correct the results of an injury, surgery to treat congenital defects (such as a cleft lip and cleft palate) necessary to restore normal bodily function, and surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.

7. Medications deemed by HealthShare to be lifestyle medications, including but not limited to those intended to treat hair loss or erectile dysfunction, or any medical services, supplies or medications for treatment of sexual dysfunction or for sexual enhancement.

8. Transsexual surgery, sex change or transformation. HealthShare does not cover any medical services, supplies or medications designed to alter, or related to alteration of, a member's

physical characteristics from his/her biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.

9. Medical services, supplies or medications for infertility, fertility testing, reversal of voluntary or involuntary sterilization, artificial insemination, in-vitro fertilization and/or any other reproductive technology, or any related charges for procurement, storage or implantation.

10. Medical services, supplies or medications for any injury or condition resulting from:

(a) military service or acts of war, declared or undeclared;
(b) failure to use standard safety equipment; or
(c) chronic abuse of alcohol or any controlled substance.

11. Medical services, supplies or medications for any self-inflicted injury or any injury sustained while:

(a) practicing for, or competing in, any professional or semi-professional athletic competition, or for any condition resulting from such participation or practice;
(b) participating in any high-risk behavior including, but not limited to, skydiving, scuba diving, bungee jumping, rock climbing, rappelling, or white-water rafting;
(c) engaged in the commission of a crime; or
(d) intoxicated or under the influence of any illegal or "street" drug, or any controlled substance unless administered on the advice of a physician.

12. Medical services or testing to determine the existence or extent of disability; any medical services or reports required as the result of, or in connection with, litigation or any legal proceeding; and any special medical report not directly related to the medical treatment of a member.

13. Adult vaccines for travel.

14. Unless preauthorized by HealthShare as part of an appropriate schedule of preventative services, the following are not covered: testing, physical exams, immunizations or other medical services, supplies or medications required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state or federal government, securing insurance coverage, travel, examinations required to participate in athletics.

15. Dental/Orthodontia, Hearing, Vision and Chiropractic Services

(a) Dental or orthodontic services (including TMJ treatment) of any kind are not included, except for repair necessitated by accidental injury to sound natural teeth after advance authorization by HealthShare;
(b) Corrective lenses, frames, contact lenses, laser or radial keratotomy or any other procedure designed to surgically correct refractive errors and any exams related to such items or services;
(c) Routine hearing or vision exams, unless due to a medical condition or injury and after advance authorization by HealthShare;
(d) Hearing aids;
(e) Chiropractic services of any kind.

16. Chronic Long-Term Care

(a) Skilled nursing, physical, occupational or home health care, if not homebound, except for acute conditions;
(b) Private-duty nursing, certified nursing assistant services, homemaker, home health aide services or
(c) Nursing home care, residential treatment center care, hospital extended care facility care, long-term rehabilitation facility and any medical services, supplies or medications received in a long-term care facility.

17. Orthopedic shoes, orthotics or footwear inserts of any kind.

18. Implants of any type, unless in connection with a surgical procedure authorized in advance by HealthShare and only if the member does not qualify for any assistance program offered by the manufacturer or distributor of the implant.

19. Behavioral Health: Any inpatient or outpatient substance abuse services.

20. Medical services, supplies or medications in excess of any of the HealthShare annual, five-year, and lifetime benefit caps.

(a) HealthShare will pay a maximum of $200,000 of services per covered individual over each individual's lifetime. This lifetime maximum includes any and all payments for any and all services, supplies and medications covered by HealthShare.
(b) HealthShare will pay a maximum of $100,000 of benefits per individual during each five-calendar-year period. This five-year maximum includes any and all payments for any and all services, supplies and medications covered by HealthShare. The five-year period is calculated on a rolling basis with a new fifth year commencing January 1 each year. (Examples: Effective January 1, 2007, the five-year period consists of January 1, 2003 and ending on December 31, 2007. Effective January 1, 2008, the five-year period changes to the period beginning on January 1, 2004 and ending on December 31, 2008.)
(c) Pharmacy benefits in excess of the annual per-member benefit limit specified in the "Using the PRESCRIPTION DRUG Program" section of this Handbook are not a covered benefit.

Once the annual and/or lifetime caps are reached, the individual and Care Manager will meet to determine potential options for coverage.

21. Inpatient private rooms or private-room differential, or any personal comfort or convenience item, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, take-home supplies and other similar items.

22. Positron emission tomography (PET) scans of any kind

23. Air ambulance services.

24. Medical services, supplies or medications (a) to which a HealthShare Protocol applies but has not been satisfied or completed; or (b) for which preauthorization is required but is not obtained, including but not limited to the following:

(a) Screening mammograms for women under age 40, without symptoms, a family history or other risk factors or who qualify for the Breast & Cervical Cancer Screening Program;
(b) Weight loss medications, programs or surgery;
(c) Elective, non-emergency surgeries within the first six months of membership;
(d) Emergency room or land ambulance services for conditions that do not meet the HealthShare definition of an Emergency Medical Condition;
(e) Pregnancy is a covered condition only if the member does not meet eligibility guidelines for Minnesota Medical Assistance programs.
(f) Nebulizers, if the member does not choose to attend the Asthma Education sessions recommended by HealthShare.

25. Medical services, supplies or medications for the treatment of sickness or injury (including without limitation Carpal Tunnel Syndrome) which is both:

(a) sustained by the member while at the member's place of work, regardless of whether the member was on-duty or off-duty at the time, or exacerbated by the member's work or is more than 50% exacerbated by the member's work; and
(b) covered by Workers' Compensation or by United States Longshoreman's and Harbor Worker's Compensation Act.

This coverage exclusion applies regardless of whether the member's employer does or does not have Workers' Compensation insurance in place. If, in the judgment of HealthShare, the sickness or injury is one to which this coverage exclusion applies, the member must apply for Workers' Compensation benefits and diligently pursue them, including but not limited to supplying additional information requested by HealthShare and, if requested by HealthShare, appealing or requesting reconsideration of any denial of Workers' Compensation benefits.

Upon a final legal determination that the injury or condition is not one for which the member is eligible to receive Workers' Compensation benefits, this exclusion will not apply and the member will be eligible for any otherwise available HealthShare services.

26. Bariatric surgery is not a covered benefit.

27. Smoking cessation classes, programs, and/or nicotine replacement supplies are not a covered benefit.

Other Coverage; Subrogation & Assigned Benefits

HealthShare coverage is always deemed to be secondary to any other health care coverage or benefits for which the member qualifies or is eligible, and the financial liability of HealthShare for a member's health care is always secondary to the liability of any insurer or other third party. Accordingly, if any or all of the member's medical services, supplies or medications are a covered benefit under any automobile or motor vehicle insurance, any homeowner's or commercial liability insurance, or any other insurance policy or contract, the member must apply for and diligently pursue such benefits.

Any medical services, supplies or medications for a member which are paid for or reimbursed by any insurer, or for which a third party pays (whether as the result of a settlement or judgment or otherwise), are not a HealthShare covered service for that member.

If HealthShare pays for any medical services, supplies or medications and you receive payment or reimbursement from or on behalf of any insurer for those same medical services, supplies or medications, you must immediately notify HealthShare of that payment or reimbursement and must also repay to HealthShare100% of the amount that HealthShare paid for those same medical services, supplies or medications. By applying for HealthShare coverage, you automatically and irrevocably assign to HealthShare all rights in and to such payments and reimbursements paid to you by or on behalf of any insurer and further agree to execute all documents, and to take all actions, as are reasonably requested by HealthShare to enable it to recover those payments and reimbursements. (As used in this paragraph and following two paragraphs, "you" includes you and any covered dependent.)

If you file or pursue any claim (whether by arbitration, lawsuit or otherwise) against a third party for injuries for which you receive medical services, supplies or medications paid for by HealthShare, and you subsequently receive a payment from or on behalf of that third party, whether as the result of an arbitration award, a settlement, a judgment or otherwise, and regardless of whether the payment is or is not designated as, or claimed to be, payment for injuries or for medical services, supplies or medications, you must immediately notify HealthShare of that payment and must also repay to HealthShare 100% of the amount that HealthShare paid for medical services, supplies and medications related to the injuries that were alleged in the claim against the third party to be the responsibility of that third party. By applying for HealthShare coverage, you automatically and irrevocably assign to HealthShare all rights in and ownership of all such payments that you receive from third parties and further agree to execute all documents, and to take all actions, as are reasonably requested by HealthShare to enable it to recover those payments.

In addition, if you suffer an injury or sickness as a result of a negligent or wrongful act or omission of any third party, HealthShare reserves the right to seek payment or reimbursement (where permitted by law) from that third party for sums that it paid for medical services, supplies, or medications for you. By applying for HealthShare coverage, you automatically and irrevocably assign to HealthShare your rights to recover all such payment or reimbursement and further agree to execute all documents, and to take all actions, as are reasonably requested by HealthShare to enable it to obtain such payment or reimbursement and to otherwise enforce its rights under this provision.

Prescription Drug Program

Using the Prescription Drug Program

To utilize your prescription drug benefit, you will need to present the prescription written by your PCC or a specialist authorized by HealthShare to one of the HealthShare participating pharmacies (See the "Participating Providers" section of this handbook). If you do not have your prescription filled at a participating pharmacy, you will be responsible for the entire cost of the prescription.

Please be sure to show the pharmacy your member card each time a prescription is filled. The pharmacy electronically verifies your coverage and the co-payment amount with our pharmacy benefit manager, based upon the information shown on your member card. If the pharmacy has a problem determining eligibility, it may call 4D Pharmacy Management Systems, Inc. directly at (877) 647-4026. If you know you are eligible for HealthShare coverage and are having a problem, please verify that the information on your card is correct and that it matches what the pharmacy has on record. Members or the pharmacy may call the HealthShare office during business hours for further assistance.

Please note that the amount of your co-payment is based upon the specific drug that your physician prescribes. If a "generic" medication is prescribed, you will pay a significantly smaller co-payment than if a "name brand" drug is prescribed. Feel free to discuss with your physician whether or not a generic drug may be appropriate for you. Prescriptions covered by another entity are not covered.

Member Prescription Cost

Standard Member Co-Payment:	Generic $12	Brand 50%	Non-Formulary 60%
Wellness Member Co-Payment:	Generic $ 7	Brand 50%	Non-Formulary 60%

Annual Prescription Limits

Standard Member:	$2,000 per year in HealthShare Payments
Wellness Member:	$3,000 per year in HealthShare Payments

Diabetic and Asthmatic Supplies

Diabetic supplies such as syringes, monitoring strips and glucometers are covered at participating pharmacies. Speak to your Care Manager for a list of recommended glucometer brands.

Complaint Resolution Process

We hope that you are satisfied with the services that you receive from HealthShare. However, there may be occasion when you may have an issue or concern that you want addressed. If you have an issue that our staff cannot resolve through normal communication channels, then you may initiate a formal grievance through HealthShare's Complaint Resolution Process which is described in this section. We will work with you to resolve your complaint as soon as possible.

You may request an external review of the final decision made about your complaint after the HealthShare appeal process or at any time in the process. A complaint can be filed with the Commissioner of Health by calling 1-800-657-3916 (toll free).

Definitions

Complainant means a member, applicant, or former member, or anyone acting on his or her behalf, who submits a complaint.

Complaint means any grievance that is not the subject of litigation concerning any aspect of the provision of health services under your HealthShare Program Handbook. If the complaint is from an applicant, the complaint must relate to the application. If the complaint is from a former member, the complaint must relate to the provision of health services during the period of time the complainant was a member.

Member means an individual who is enrolled in the HealthShare coverage program.

HealthShare Complaint Resolution Process

1. If there is a complaint or issue, we suggest that you first contact the Member Services staff either by telephone or come into the office. We will work to resolve your verbal complaint within 10 business days.

2. If you are not satisfied with how your verbal complaint was resolved, you may submit your complaint in writing. We suggest that you use HealthShare's complaint resolution form that will include all the necessary information to file your complaint. The Member Services staff will provide you a complaint resolution form upon request. If you need assistance, we will complete the written complaint form and mail it to you for your signature. You are entitled to examine all pertinent documents and to submit issues and comments in writing.

3. Once HealthShare receives your written complaint, we will send you a letter to notify you of receipt.

4. Within 30 days of receipt of the written complaint, HealthShare will send you written notification of our decision and the reasons for the decision. If we are unable to make a decision within 30 days due to circumstances outside our control, we may take up

to 14 additional days to make a decision. If we take more than 30 days to make a decision, we will inform you of the reasons for the extension.

5. If our decision regarding a complaint is partially or wholly adverse to you, you may request a voluntary appeal of the decision. You may choose to engage in the voluntary appeal process by requesting either 1) a hearing with HealthShare or 2) filing a written reconsideration.

6. If you request a hearing for the voluntary appeal process, HealthShare will schedule a date for a hearing within 10 business days of your request. The hearing will be scheduled no later than 45 days from the date of your request for a hearing. At the hearing, you or any person you choose may present testimony or other information.

   If you request a written reconsideration for the voluntary appeal process, you may provide us any additional information you believe is necessary.

7. Within 30 days after we receive your request for a written reconsideration or after the hearing, HealthShare will provide you written notice of our decision and all key findings.

External Review

If your complaint concerns a health care service or claim and you believe HealthShare's voluntary appeal determination is wholly or partially adverse to you, you or anyone you authorize to act on your behalf may submit the adverse determination to external review.

You may request external review by contacting the Department of Health at:

Minnesota Department of Health
Managed Care Systems Section
P.O. Box 74975
St. Paul, MN 55164-0975
1-800-657-3916 (toll free)

The State of Minnesota has contracted with an independent organization that meets the State's requirements to conduct external review of health-related disputes. The written request must be submitted to the Commissioner of Health along with a filing fee of $25.00. The Commissioner may waive the fee in cases of financial hardship.

The external review entity will notify you and HealthShare that it has received your request for external review. Within 10 business days of receiving notice from the external review entity, you and HealthShare must provide the external review entity any information to be considered. Both you and HealthShare will be able to present a statement of facts and arguments. You may be assisted or represented by any person of your choice at your expense. The external review entity will send written notice of its decision to you, HealthShare, and the Commissioner within 40 days of receiving the request for external review. The external review entity's decision is binding on HealthShare, but not binding on you.

Termination of Coverage

Termination of Individual Membership

The employer must notify HealthShare of the termination of coverage for any employee, whether because the employee fails to meet any of the employee eligibility criteria or because the employee no longer wishes to participate in the HealthShare program. HealthShare must receive notice of the termination prior to the 5th day of the final month of coverage. If the termination notice is received after the 5th day of that month, the termination will become effective on the last day of the following month, and the member and employer will be obligated to pay the premium for that following month. There are no refunds or proration of charges.

Example: Member Judy Jones has married and, on July 1, she will become eligible for health coverage under her husband's work-sponsored health insurance program. Thus, on July 1, she will no longer be eligible for HealthShare coverage. Judy must notify her employer, and her employer must notify HealthShare about this important change by June 5 in order to avoid liability for premiums for July. If Joanne's employer does not notify HealthShare by June 5, Judy and her employer will be required to pay the HealthShare premium for Judy for the month of July.

Termination of Membership of Entire Employer Group

For a business to terminate HealthShare coverage for all of its employee members, the business must submit a written termination request 30 days prior to the desired date of coverage termination.

Termination by HealthShare

HealthShare may prospectively or retroactively terminate the HealthShare coverage of an entire employer group and/or an individual member for, among other things, any of the following:

- The employer or member fails to meet applicable eligibility criteria;
- Late, partial, or untimely payment of monthly coverage charges;
- Abusive language or actions toward the HealthShare staff or participating providers;
- The employer or member knowingly or unknowingly provides any false or misleading information to HealthShare at any time;
- Failure or refusal by the employer or member to provide information reasonably requested by HealthShare, including but not limited to, information necessary to determine program eligibility, process claims, resolve Grievances or coordinate a member's medical care;

- Failure to maintain in place all legally required Workers' Compensation insurance coverage;

- Breach of the HealthShare Employer Contract, any HealthShare policy, procedure, or any obligation under this Handbook or another HealthShare document;

- Failure to cooperate or comply with obligations and policies regarding assignment or coordination of benefits and/or subrogation, including failure or refusal to pay or reimbursement to HealthShare any sum required in connection with those activities;

- Termination of the entire HealthShare program.

Definitions:

The following definitions may help you better understand terms used in this Handbook. These definitions are summarized and may be superseded by other provisions of this Handbook.

Authorization—Issued by HealthShare so that HealthShare will provide payment for services. Medical services that require authorization prior to receiving the service will not be covered unless the authorization is issued.

Covered Services—Medical services, supplies or medications that are medically necessary, are not provided primarily for the convenience of the member, are described as being a HealthShare covered service, and are not included on any list of coverage Exclusions.

Co-payment (Co-Pay)—The member's portion of the cost for the service. You are required to pay this amount when you receive the service.

Designated Employee Group—A group of employees, specifically identified by the employer, that have common characteristics of work hours (full time, part time, etc.) or employment status (hourly, exempt, non-exempt, job grade, not considered part of management, etc.). The employer determines their own Designated Employee Groups.

Eligible Member or Family Member—An employee or dependent that is eligible for services under the HealthShare Plan as outlined in the Eligibility section.

Exclusions & Non-covered Services—Services that are not a Service.

Experimental Service or Treatment—A service, procedure, treatment, device or supply that has not been found to be scientifically safe and /or effective for treatment of a medical condition.

Emergency Medical Condition—A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson

with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) serious jeopardy to the health of the individual or, in the case of a pregnant woman, to the health of the woman or her unborn child; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Member Card—A card that you will receive after you become a member of HealthShare and which you should present each time you receive services.

Primary Care Clinic (PCC)—The medical clinic that serves as the member's point of contact and, partnering with HealthShare, coordinates all of the member's medical care.

Protocols—Requirements that must be met prior to certain health services being authorized for payment.

Provider—A person or entity that provides medical services or care. Providers include doctors, nurses, nurse practitioners, labs, X-ray facilities, hospitals, and pharmacists.

Participating Provider—A provider who has an agreement with HealthShare to provide services to our members.

Referral—A request made by your PCC for you to receive a specified medical service that is not performed by the PCC.

Specialist—HealthShare defines a Specialist as any provider that specializes in an area of medicine OTHER THAN family or general practice, internal medicine, or pediatrics.

Privacy Notice

Health Insurance Portability and Accountability Act (HIPAA)

This notice describes how medical information about you may be used or disclosed, and how to get access to this information. This Notice describes, in accordance with the HIPAA Privacy Regulation, how HealthShare, referred to as "we" or "us", may use and disclose your protected health information to carry out treatment, payment, health care operations, and for other specific purposes that are permitted as required by law. The Notice also describes your rights and HealthShare's duties with respect to protected health information about you.

Our Commitment Regarding Your Protected Health Information

We understand the importance of your Protected Health Information, hereafter referred to as "PHI," and follow strict policies in accordance with state and federal privacy laws to keep your PHI private. PHI is information about you, including demographic data, that can reasonably be used to identify you and that relates to your past, present or future

physical or mental health, and the provision of health care to you or the payment for that care. In this notice, we explain how we protect the privacy of your PHI, and how we will allow it to be used and disclosed. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect May 1, 2008, and will remain in effect until we replace or modify it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. Any revised practice will apply to your PHI regardless of when your PHI was created or received. Before we make a material change to our privacy practices, we will mail a revised notice to you. Where multiple state or federal laws protect the privacy of your PHI, we will follow the requirements that provide the greatest privacy protection.

Our Uses and Disclosures of Protected Health Information

We do not sell your PHI to anyone or disclose your PHI to other companies who may want to sell their products to you (e.g., catalog or telemarketing firms). We must have your written authorization to use and disclose your PHI, except for the following uses and disclosures:

- **To You and Your Personal Representative**
  We may disclose your PHI to you or to your personal representative (someone who has the legal right to act for you) or someone you designate to receive information. A designation form must be completed to disclose information.

- **For Treatment**
  We may use and disclose your PHI to health care providers (e.g., doctors, dentists, pharmacies, hospitals, clinics, community safety net providers, and other caregivers) in connection with your treatment or request for services. For example, we may disclose your PHI to health care providers in connection with disease and case management programs.

- **For Payment**
  For our payment-related activities, we may use and disclose your PHI to health care providers, health plans or third-party administrators, including, for example:

  Obtaining payment history and determining eligibility for benefits;

  Paying claims for health care services that are covered benefits;

  Responding to inquiries, appeals, and Grievances;

  Coordinating eligibility with other payers, such as the Breast and Cervical Cancer Screening Program, Medical Assistance, or Lake Superior Community Health Center.

- **For Health Care Operations**

We may use and disclose your PHI for our health care operations—including, for example:

Conducting quality assessment and improvement activities, including peer review;

Performing outcome assessments and health claims analysis;

Preventing, detecting and investigating fraud and abuse;

Coordinating care and disease management activities;

Communicating with you about treatment alternatives or other health-related benefits and services;

Performing business management and other general administrative activities, including systems management and customer service;

Determining eligibility for our program or other programs that we partner with, such as Medical Assistance or the Breast & Cervical Cancer Screening Program.

- **To Others Involved In Your Care**
  We may under certain circumstances disclose to a member of your family, a relative, a close friend or any other person you identify, the PHI directly relevant to that person's involvement in your health care or payment for health care. For example, we may discuss a claim determination with you in the presence of a friend or relative with your permission.

- **When Required by Law**
  We will use and disclose your PHI if we are required to do so by law. For example, we will use and disclose your PHI in responding to court and administrative orders and subpoenas, and to comply with workers' compensation laws. We will disclose your PHI when required by the Department of Health and Human Services and state regulatory authorities.

- **For Research**
  We may use your PHI to perform select research activities, provided that certain established measures to protect your privacy are in place.

- **To Our Business Associates**
  From time to time we engage third parties to provide various services for us. Whenever an arrangement with such a third party involves the use or disclosure of your PHI, we will have a written contract with that third party designed to protect the privacy of your PHI. For example, we may share your information with business associates who process claims or conduct disease management programs on our behalf.

- **To Your Employer**
  Your employer may receive PHI, but your employer must follow applicable laws governing the use and disclosure of your PHI.

Disclosures You May Request

You may instruct us, and give your written authorization, or disclose your PHI to another party for any purpose. We require your authorization to be on our standard form. To obtain a copy of the form, call the customer service number printed on the back of your identification card or call: HealthShare at (218) 336-5711.

Individual Rights

You have the following rights listed below. To exercise these rights you must make a written request on our standard form. To obtain the form call the customer service number printed on the back of your identification card or call HealthShare at (218) 336-5711.

- **Access**
  With certain exceptions, you have the right to look at or receive a copy of your PHI, contained in the group of records that are used by or for us to make decisions about you, including our enrollment, payment, claims adjudication and case or medical management notes. We reserve the right to charge a reasonable cost-based fee for copying and postage. If you request an alternative format, such as a summary, we may charge a cost-based fee for preparing the summary. If we deny your request for access, we will tell you the basis for our decision and whether you have a right to further review.

- **Disclosure Accounting**
  You have the right to an accounting of certain disclosures of your PHI, such as disclosures required by law. If you request this accounting more than once in a 12-month period, we may charge you a fee that covers the cost of responding to these additional requests.

- **Restriction Requests**
  You have the right to request that we place restrictions on the way we use or disclose your PHI for treatment, payment or health care operations. We are not required to agree to these additional restrictions; but if we do, we will abide by them (except as needed for emergency treatment or as required by law) unless we notify you that we are terminating our agreement.

- **Amendment**
  You have the right to request that we amend your PHI in the set of records described above under Access. If we deny your request, we will provide you a written explanation. If you disagree, you may have a statement of your disagreement placed in our records.

  If we accept your request to amend the information, we will make reasonable efforts to inform others, including the individuals you name, of the amendment.

Confidential Communication

Our communications with you, such as decisions related to payment and benefits, may contain PHI. If you believe that this practice may endanger you, you may request that we communicate with you by reasonable alternative means or at an alternative location. For example, an individual may request that we send correspondence to a post office box instead of to a home address. To request confidential communications, call the customer service number printed on the back of your membership card, or call HealthShare at 218-336-5710.

Questions or Complaints: Contact the HIPAA Privacy Officer

Call 218-336-5710 or mail your complaint to HealthShare, 130 W. Superior Street, Suite 700, Duluth, MN 55802

If you are concerned that we may have violated your privacy rights, or if you believe that we have inappropriately used or disclosed your PHI, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with their address to file your complaint upon request. We support your right to protect the privacy of your PHI. We will not take action against you if you file a complaint with us or with the U.S. Department of Health and Human Services.

PARTICIPATING HEALTH CARE ORGANIZATIONS

NOTE: This list is only a general guide. It will change as participating providers are added or deleted, so for the most up to date list, please visit www.HealthShareMN.com or call HealthShare at 218-336-5710.

Primary Care Clinics:

Bay Area Medical Clinic	50 Outer Drive, Silver Bay	218-226-4431
Denfeld Medical Center	4702 Grand Ave, Duluth	218-249-6800
Duluth Clinic - General Internal Medicine	420 E First St, Duluth	218-786-3337
Duluth Clinic - Pediatrics	420 E First St, Duluth	218-786-3400
Duluth Clinic Hermantown	4855 W Arrowhead Rd, Hermantown	218-786-3540
Duluth Clinic Lakeside	4621 E Superior St, Duluth	218-786-3550
Duluth Clinic West	4212 Grand Ave, Duluth	218-786-3500
Duluth Family Practice Center	330 N 8th Ave E, Duluth	218-723-1112
Kundel Pediatric Associates	1000 E 1st St, Ste 204, Duluth	218-722-1408
Lake Superior Community Health Center	4325 Grand Ave, Duluth	218-722-1497
Lake Superior Internal Medicine	324 W Superior St, Duluth	218-727-0080
Lake View Clinic	1010 4th St, Two Harbors	218-834-7200
Lester River Medical Clinic	6351 E Superior St, Duluth	218-249-4500
Miller Creek Medical Clinic	4884 Miller Trunk Hwy	218-249-4600
Mount Royal Medical Clinic	1400 Woodland Ave, Duluth	218-249-8800
P.S. Rudie & Associates	324 W Superior St, Ste 302, Duluth	218-722-6613
St. Luke's Duluth Internal Medicine Assoc.	324 W Superior St, Ste 220, Duluth	218-249-3500
St. Luke's Internal Medicine Associates	1001 E Superior St, Duluth	218-249-7960

St. Luke's Pediatric Associates	1000 E 1st St, Ste N105, Duluth	218-249-7870
SuperiorHealth Center	211 S Boundary Ave, Duluth	218-624-4819
SuperiorHealth Center	1502 London Rd, Duluth	218-727-8228

Specialty Clinics *(Referral required. Call 336-5706 prior to appt.)*:

Allergy

Duluth Clinic - Allergy	400 E Third St, Duluth	218-786-8364
St. Luke's Allergy Immunology Associates	920 E 1st St, Ste P201, Duluth	218-249-7920

Anesthesiology

Duluth Clinic - Anesthesiology	400 E Third St, Duluth	218-786-8364
St. Luke's Anesthesia Associates	915 E 1st St, Duluth	218-249-5555

Cancer Care

Duluth Clinic - Cancer Center	400 E Third St, Duluth	218-786-8364
St. Luke's Cancer Care Center	1001 E Superior St, Ste L101, Duluth	218-249-7800

Dermatology

Duluth Clinic - Dermatology	400 E Third St, Duluth	218-786-8364
St. Luke's Dermatology Associates	920 E 1st St, Ste P201, Duluth	218-249-7930

Diabetes Care

Duluth Clinic - Diabetes Care	400 E Third St, Duluth	218-786-8364
St. Luke's Diabetes Care	915 E 1st St, Duluth	218-249-5231

Ear, Nose, & Throat

Duluth Clinic - Audiology	400 E Third St, Duluth	218-786-8364
Duluth Clinic - Otolaryngology	400 E Third St, Duluth	218-786-8364
Northland Ear, Nose & Throat Assoc.	920 E 1st St, Ste 301, Duluth	218-279-6279

Elder Care

Duluth Clinic - Elder Care	400 E Third St, Duluth	218-786-8364

Endocrinology

Duluth Clinic - Endocrinology	400 E Third St, Duluth	218-786-8364
St. Luke's Endocrinology Associates	1011 E 1st St, Duluth	218-249-7890

Gastroenterology

Duluth Clinic - Gastroenterology	400 E Third St, Duluth	218-786-8364
Northland Gastroenterology, P.A.	1420 London Rd, Duluth	218-724-3411
St. Luke's Gastroenterology Associates	920 E 1st St, Ste P201, Duluth	218-249-7940

Heart Health

Duluth Clinic - Cardiology	400 E Third St, Duluth	218-786-8364
Duluth Clinic - Heart Center	400 E Third St, Duluth	218-786-8364
St. Luke's Cardiology Associates	1001 E Superior St, Ste L201, Duluth	218-249-3057

Hospice

Duluth Clinic - Hospice & Palliative Care	400 E Third St, Duluth	218-786-8364
St. Luke's Hospice Duluth	220 N 6th Ave E, Duluth	218-249-6100

Infectious Disease

Duluth Clinic - Infectious Disease	400 E Third St, Duluth	218-786-8364
St. Luke's Infectious Disease Associates	1001 E Superior St, Duluth	218-249-7990

Mental Health

Duluth Clinic - Behavioral Health	400 E Third St, Duluth	218-786-8364
Human Development Center	1401 E 1st St, Duluth	218-728-4491
St. Luke's Mental Health Services	220 N 6th Ave E, Duluth	218-249-7000

Neonatology

Duluth Clinic - Neonatology	400 E Third St, Duluth	218-786-8364

Nephrology

Duluth Clinic - Nephrology	400 E Third St, Duluth	218-786-8364
Duluth Kidney Services, LLC	925 E Superior St, Ste 106, Duluth	218-249-6230

Neurology / Neurovascular

Duluth Clinic - Neurology	400 E Third St, Duluth	218-786-8364
Duluth Clinic - Neurovascular	400 E Third St, Duluth	218-786-8364
Northland Neurology & Myology	1000 E 1st St, Ste 202, Duluth	218-722-1122

Ob/Gyn

Duluth Clinic - Obstetrics & Gyn	400 E Third St, Duluth	218-786-8364
Duluth Clinic - Women's Health Services	400 E Third St, Duluth	218-786-8364

Oncology / Hematology

Duluth Clinic - Hematology & Oncology	400 E Third St, Duluth	218-786-8364
Duluth Clinic - Oncology	400 E Third St, Duluth	218-786-8364
Duluth Clinic - Pediatric Oncology	400 E Third St, Duluth	218-786-8364
Duluth Clinic - Radiation Oncology	400 E Third St, Duluth	218-786-8364
St. Luke's Oncology & Hematology Assoc.	1001 E Superior St, Ste L101	218-249-3081
St. Luke's Radiation Oncology Associates	1001 E Superior St, Ste L101	218-249-7800

Ophthalmology / Optometry

Austin & Treacy, P.A.	324 W Superior St, Ste 800, Duluth	218-722-6655
Duluth Clinic - Ophthalmology	400 E Third St, Duluth	218-786-8364
Duluth Clinic - Optometry	400 E Third St, Duluth	218-786-8364
Miller Creek Medical Clinic	4884 Miller Trunk Hwy	218-249-4600
Relf Eye Associates	5007 Matterhorn Dr, Duluth	218-720-3553

Orthopedics

Duluth Clinic - Orthopedics	400 E Third St, Duluth	218-786-8364
Orthopaedic Associates of Duluth, P.A.	1000 E 1st St, Ste 404	218-722-5513
St. Luke's Orthopedics	1000 E 1st St, Ste N305	218-249-6360

Pain Management

Duluth Clinic - Pain Management	400 E Third St, Duluth	218-786-8364

Pathology / Laboratory

Duluth Clinic - Pathology	400 E Third St, Duluth	218-786-8364

Laboratory Medicine Specialists of Duluth	915 E 1st St, Duluth	218-249-5208
St. Luke's Pathology	915 E 1st St, Duluth	218-726-5208

Podiatry

Duluth Clinic - Podiatry	400 E Third St, Duluth	218-786-8364
Northern Foot & Ankle	324 W Superior St, Ste 408	218-722-0615

Physical, Occupational, & Speech Therapy

Duluth Clinic - Occupational Medicine	400 E Third St, Duluth	218-786-8364
Duluth Clinic - Physical Med & Rehab	400 E Third St, Duluth	218-786-8364
Duluth Clinic Fitness & Therapy Center	502 E Second St, Duluth	218-786-5410
In Motion Therapy	2711 W Superior St #209, Duluth	218-727-1180
Novacare Rehabilitation	925 E Superior St, Duluth	218-728-1100
Polinsky Medical Rehab Center	530 E Second St, Duluth	218-786-5360
St. Luke's Occupational Health Clinic	4702 Grand Ave., Duluth	218-249-6822
St. Luke's Physical Medicine & Rehab Associates	920 E 1st St, Ste P302, Duluth	218-249-6980
Turning Point Therapy	1420 London Rd, Ste 102, Duluth	218-728-3774
Turning Point Therapy	211 S Boundary Ave, Proctor	218-624-5215

Pulmonary Medicine

Duluth Clinic - Pulmonary Medicine	400 E Third St, Duluth	218-786-8364
St. Luke's Pulmonary Medicine	920 E 1st St, Ste P201, Duluth	218-249-7970

Radiology

Duluth Clinic - Radiology	400 E Third St, Duluth	218-786-8364

Radiological Associates of Duluth, LTD	925 E Superior St, Ste 109, Duluth	218-722-3700

Rheumatology

Duluth Clinic - Rheumatology	400 E Third St, Duluth	218-786-8364
St. Luke's Rheumatology Associates	1000 E 1st St, Ste N203, Duluth	218-249-6960

Sleep Medicine

Duluth Clinic - Sleep Medicine	400 E Third St, Duluth	218-786-8364
St. Luke's Sleep Center	915 E 1st St, Duluth	218-249-7970

Sports Medicine

Duluth Clinic - Sports Medicine	400 E Third St, Duluth	218-786-8364

Surgeons

Duluth Clinic - Cardiothoracic Surgery	400 E Third St, Duluth	218-786-8364
Duluth Clinic - General Surgery	400 E Third St, Duluth	218-786-8364
Duluth Clinic - Vascular Surgery	400 E Third St, Duluth	218-786-8364
Northland Center for Plastic & Reconstructive Surgery	1420 London Rd, Duluth	218-724-7363
St. Luke's Cardiothoracic Surgery Associates	920 E 1st St, Ste P302, Duluth	218-249-6050
St. Luke's Duluth Neurosurgical Institute	920 E 1st St, Ste P303, Duluth	218-249-2450
St. Luke's Pavilion Surgical Associates	920 E 1st St, Ste P302, Duluth	218-249-6050
St. Luke's Plastic Surgical Associates	920 E 1st St, Ste P201, Duluth	218-249-7910
St. Luke's Surgical Associates	920 E 1st St, Ste P201, Duluth	218-249-7950

Toxicology

Duluth Clinic - Toxicology	400 E Third St, Duluth	218-786-8364

Urology

Duluth Clinic - Urology	400 E Third St, Duluth	218-786-8364
Northland Urology Associates PA	1000 E 1st St, Ste 306, Duluth	218-727-8414
St. Luke's Urology Associates	1001 E Superior St, Ste L201, Duluth	218-249-7980

Urgent Care Centers

Denfeld Medical Center	4702 Grand Ave., Duluth	218-786-3540
Duluth Clinic Urgent Care	400 E Third St, Duluth	218-786-8364
Miller Creek Medical Clinic	4884 Miller Trunk Hwy, Duluth	218-249-4600
Q-Care St. Luke's Express Clinic	Cub Foods, 619 W Central Entrance, Duluth	
St. Luke's Urgent Care	915 E 1st St, Duluth	218-249-6095

Hospitals & Surgery Centers *(Referral required. Call 336-5706 prior to appt.)*

Lake View Memorial Hospital	325 11th Ave, Two Harbors	218-834-7300
Miller-Dwan Medical Center	502 E Second St, Duluth	218-727-8762
Pavilion Surgery Center, LLC	920 E 1st St, Ste 101, Duluth	218-279-6200
St. Luke's Hospital	915 E 1st St, Duluth	218-249-5555
St. Mary's Medical Center	407 E Third St, Duluth	218-786-4000

Durable Medical, Orthotics, Prosthetics (Referral required. Call 336-5706 prior to appt.):

Duluth Clinic Orthotics & Prosthetics	400 E Third St, Duluth	218-786-4368
Midwest Medical Equipment & Supplies	4418 Haines Rd, Ste 1200, Duluth	218-722-3420
Midwest Medical Orthotics & Prosthetics	530 E 2nd St, Duluth	218-786-4368

Pharmacies:

Cub Foods Pharmacy	615 W Central Entrance, Duluth	218-727-3010
Falk's Kenwood Pharmacy	1352 W Arrowhead Rd, Duluth	218-724-8825
Duluth Clinic 1st St Pharmacy	420 E 1st St, Duluth	218-786-1685
Duluth Clinic 3rd St Pharmacy	400 E 3rd St, Duluth	218-786-3137
Duluth Clinic Hermantown Pharmacy	4855 W Arrowhead Rd, Hermantown	218-786-3549
Duluth Clinic Lakeside Pharmacy	4619 E Superior St, Duluth	218-786-3784
Duluth Clinic West Pharmacy	4212 Grand Ave, Duluth	218-786-3700
Falk's Lakeside Pharmacy	4507 E Superior St, Duluth	218-525-1916
Falk's Mount Royal Pharmacy	1600 Woodland Ave, Duluth	218-740-5600
Falk's Newman Pharmacy	2908 W 3rd St, Duluth	218-624-5755
Falk's Spirit Valley Pharmacy	5300 Bristol St, Duluth	218-624-1222
Falk's Woodland Pharmacy	1 E Calvary Rd, Duluth	218-728-4242
Kmart Pharmacy	1734 Mall Drive, Duluth	218-727-3477

Kmart Pharmacy	215 N Central Ave, Duluth	218-624-9305
Medical Arts Pharmacy	324 W Superior St, Duluth	218-722-1401
Northland Pharmacy	1000 E 1st St, Duluth	218-249-2460
Pasek Pharmacy	116 W 1st St, Duluth	218-722-3977
Shopko Pharmacy	801 W Central Entrance, Duluth	218-727-7139
SuperiorHealth Pharmacy-Lakewalk	1502 London Rd, Duluth	218-733-1110
SuperiorHealth Pharmacy-Silver Bay	99 Edison Blvd, Ste L	218-226-3829
SuperiorHealth Pharmacy-Two Harbors	1010 4th St, Two Harbors	218-834-7202
Target Stores Pharmacy	1902 Miller Trunk Hwy, Duluth	218-727-8475
Walgreen Drug Store	4501 Grand Ave, Duluth	218-628-2897
Walgreen Drug Store	1201 Miller Trunk Hwy, Duluth	218-727-8157
Walgreen Drug Store	1301 E Superior St, Duluth	218-724-3060

Contact Us:

How to Reach HealthShare:

Location: 130 West Superior Street, Suite 700, Duluth, MN 55802
Phone: 218-336-5710
Fax: 218-336-5719
Hours: 8 a.m. to 5 p.m. Monday-Friday and closed holidays
Web Site: www.healthsharemn.com

Check the Web site often for current plan information, updates and forms.

Important HealthShare Contacts:

Member Services Representative	**336-5711**	Business and employee questions about enrollments, terminations, physician changes, and new cards. Form requests. Provider contracts and physician update. Business payment questions, premium billing, and late payments.
Care Manager	**336-5706**	Medical treatment and protocol questions. Referrals, Authorizations, and Medical Documentation. To schedule wellness health advising appointments and classes with the Care Manager. If your business is interested in doing a wellness group meeting or workshop.
Employer Services Representative	**336-5710**	Businesses interested in offering HealthShare Business applications

McGladrey & Pullen
Certified Public Accountants

HealthShare, Inc.

Financial Report

June 30, 2009

Contents

McGladrey & Pullen
Certified Public Accountants

Independent Auditor's Report

To the Board of Directors
HealthShare, Inc.
Duluth, Minnesota

We have audited the accompanying balance sheet of HealthShare, Inc. as of June 30, 2009, and the related statements of activities and cash flows for the year then ended. These financial statements are the responsibility of the Corporation's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of HealthShare, Inc. as of June 30, 2009, and the changes in its net assets and its cash flows for the year then ended, in conformity with accounting principles generally accepted in the United States of America.

McGladrey & Pullen, LLP

Duluth, Minnesota
October 2, 2009

HealthShare, Inc.

Balance Sheet
June 30, 2009

Assets		
Cash	$	46,750
Receivables		423
Prepaid expenses		3,505
Total assets	$	50,678
Liabilities and Net Assets		
Liabilities		
Accounts payable:		
Trade	$	9,327
Generations Health Care Initiatives		17,899
Accrued expenses		15,162
Liability for incurred but not reported claims		5,000
Deferred program revenue		3,290
Total liabilities		50,678
Unrestricted Net Assets		-
	$	50,678

See Notes to Financial Statements.

HealthShare, Inc.

Statement of Activities
Year Ended June 30, 2009

Revenues		
Program:		
Wellness	$	11,201
Standard		774
Grants:		
State of Minnesota		293,428
Generations Health Care Initiatives		89,311
Other		5,786
Total revenues		400,500
Expenses		
Claims:		
Provider payments:		
Medical		12,754
Pharmacy		915
Claims processing		11,000
Total claims expense		24,669
Sales and Marketing:		
Salaries and benefits		56,228
Supplies and expense		3,616
Marketing		26,561
Travel		1,662
Other		1,472
Total sales and marketing expense		89,539
Administrative and General:		
Salaries and benefits		218,915
Consulting		5,000
Supplies and expense		2,658
Professional fees		18,652
Occupancy		19,286
Maintenance and repairs		296
Personnel		2,889
Travel		7,632
Other		1,104
Insurance		9,110
Fees		750
Total administrative and general expense		286,292
Total expenses		400,500
Change in net assets		-
Unrestricted Net Assets		
Beginning of year		-
End of year	$	-

See Notes to Financial Statements.

HealthShare, Inc.

Statement of Cash Flows
Year Ended June 30, 2009

Cash Flows from Operating Activities		
Change in net assets	$	-
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Changes in assets and liabilities:		
Receivables		(423)
Prepaid expenses		(3,505)
Accounts payable		27,226
Accrued expenses		15,162
Liability for incurred but not reported claims		5,000
Deferred program revenue		3,290
Net cash provided by operating activities		46,750
Net increase in cash		46,750
Cash		
Beginning		-
Ending	$	46,750

See Notes to Financial Statements.

Note 1. Nature of Business and Significant Accounting Policies

Nature of business: HealthShare, Inc. (the Corporation), located in Duluth, Minnesota, began operations on July 1, 2008. The Corporation is a Minnesota nonprofit corporation whose purpose is to develop and operate a multi-share health coverage program (Program) in Northeastern Minnesota. The Program offers health coverage through a network of local providers to employees of small businesses with a median wage less than or equal to $12.50 per hour. Employers and employees share a monthly fee for coverage, which is subsidized by a grant from the State of Minnesota and funding from Generations Health Care Initiatives, Inc. Minnesota Statute 62Q.80 provides special authority to operate HealthShare as a five-year demonstration project that expires December 31, 2012.

A summary of the Corporation's significant accounting policies follows:

Cash: The Corporation maintains its cash in bank deposit accounts, which, at times, may exceed federally insured limits. The Corporation has not experienced any losses in such accounts.

Incurred but not reported claims: The Corporation estimates the liability for incurred but not reported claims by using various inputs including average claim cost per member per month, monthly cumulative claim expense totals and lag report information. Such liabilities are necessarily based on estimates and, while management believes that the amount is adequate, the ultimate liability may be in excess of or less than the amounts provided. The methods for making such estimates and for establishing the resulting liability are continually reviewed, and any adjustments are reflected in earnings currently.

Deferred program revenue: The Corporation invoices member businesses in advance for the monthly fee for coverage. The balance in deferred program revenue represents the fees received in advance for these services.

Revenue recognition: The Corporation records grant revenue as earned. Program revenue is recorded as earned during the month the coverage is provided.

Income taxes: The Corporation has applied to be exempt from federal income tax under section 501(a) of the Internal Revenue Code as an organization described in section 501(c)(3). Management believes they will be granted tax exempt status.

Net assets: Net assets are classified as unrestricted since no donor restrictions on contributions exist.

Use of estimates in the preparation of financial statements: The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Note 2. Rent Subsidy

The Corporation received subsidized rent in the amount of $5,786 for the year ended June 20, 2008. The rent subsidy is recorded as revenue and expense at the estimated fair market value.

Note 3. Future Funding

The Corporation is subsidized through a grant from the State of Minnesota. The initial grant of $1.06 million is for a five-year period for services through 2012 subject to annual funding approved by the State of Minnesota. Funding of the grant for the year ending June 30, 2010 has been authorized by the State in the amount of $208,000. The Corporation has also been awarded a Federal grant of up to $445,000 for the year ended June 30, 2010 for qualifying expenditures.