

The following is an overview of your HealthPartners coverage. For exact coverage terms and conditions, consult your plan materials, or call Member Services at (952) 883-5000 or 1-800-883-2177.

<b>Plan highlights</b> Partial listing of covered services	<b>In-network</b> Care from a network provider	<b>Out-of-network</b> Care from an out-of-network provider
<b>Deductible and Out-of-Pocket</b>		
Lifetime maximum	Unlimited	\$1,000,000
Plan year deductible	\$300 per person; \$600 per family	\$500 per person; \$1,000 per family
Plan year medical out-of-pocket maximum	\$1,500 per person; \$3,000 per family	\$4,000 per person; \$7,000 per family
<b>Preventive Health Care</b>		
▪ Routine physical & eye exams, well-child care	100% coverage	No coverage
▪ Prenatal & postnatal care	100% coverage	65% coverage after deductible
▪ Immunizations	100% coverage	No coverage
<b>Office Visits</b>		
▪ Illness or injury	\$35 copayment	65% coverage after deductible
▪ Allergy injections	100% coverage	65% coverage after deductible
▪ Physical, occupational & speech therapy	\$35 copayment	65% coverage after deductible
▪ Chiropractic care (neuromusculo-skeletal conditions only)	\$35 copayment	65% coverage after deductible
▪ Mental health care	\$35 copayment	65% coverage after deductible
▪ Chemical health care	\$35 copayment	65% coverage after deductible
<b>Convenience Care</b>		
▪ Convenience clinics (retail clinics), eVisits	\$15 copayment	65% coverage after deductible
<b>Emergency Care</b>		
▪ Urgently needed care at an urgent care clinic or medical center	\$35 copayment	80% coverage after in-network deductible
▪ Emergency care at a hospital ER	\$100 copayment	80% coverage after in-network deductible
▪ Ambulance	80% coverage after deductible	80% coverage after in-network deductible
<b>Inpatient Hospital Care</b>		
▪ Illness or injury	80% coverage after deductible	65% coverage after deductible
▪ Mental health care	80% coverage after deductible	65% coverage after deductible
▪ Chemical health care	80% coverage after deductible	65% coverage after deductible
<b>Outpatient Care</b>		
▪ Scheduled outpatient procedures	80% coverage after deductible	65% coverage after deductible
▪ Outpatient MRI and CT scan	80% coverage after deductible	65% coverage after deductible
<b>Durable Medical Equipment</b>		
▪ Durable medical equipment & prosthetics	80% coverage after deductible	65% coverage after deductible
<b>Prescription Drugs</b> (30-day supply; 1 cycle of oral contraceptives; 90-day supply for mail order)	<b>HealthPartners Participating Pharmacy Benefit</b>	<b>Non Participating Pharmacy Benefit</b>
▪ <b>Specialty Drugs</b>	80% coverage; member will pay a maximum copayment of \$200 per prescription per month	65% coverage after deductible
▪ <b>Retail Pharmacy Copayment for 1-month supply</b>		
▪ Generic Preferred	\$14.80 copayment	65% coverage after deductible
▪ Brand Preferred	\$35 copayment	65% coverage after deductible
▪ NonPreferred	\$60 copayment	65% coverage after deductible
▪ <b>HealthPartners Mail Order Pharmacy Copayment for 3-month supply</b>		
▪ Generic Preferred	\$29.60	
▪ Brand Preferred	\$70 copayment	
▪ NonPreferred	\$120 copayment	