HealthPartners Distinctions[SM] II

Ramsey County 2020

The following is an overview prepared by Ramsey County. For exact coverage terms, and conditions, consult your plan materials available through HealthPartners Member Services at (952) 883-5000 or 1-800-883-2177.

Plan highlights Partial listing of covered services	In-network Care from a network provider	Out-of-network Care from an out-of-network provider
Deductible and Out-of-Pocket		
Lifetime maximum	Unlimited	$1,000,000
Calendar year deductible	$25 per person; $75 per family	$750 per person; $2,100 per family
Calendar year medical out-of-pocket maximum	$1,200 per person; $2,400 per family	$3,500 per person; $8,500 per family
Calendar year prescription out-of-pocket maximum	$1,200 per person; $2,400 per family, combined for in-network and out-of-network	
Preventive Health Care		
Routine physical & basic eye examinations, well-child care	100% coverage	No Coverage
Prenatal and postnatal care	100% coverage	You pay 35% after deductible
Immunizations	100% coverage	No Coverage
Office Visits		
Illness or injury	Healthy Benefits: - $25 Benefit Level 1 after deductible - $40 Benefit Level 2 after deductible No Healthy Benefits: - $45 Benefit Level 1 after deductible - $60 Benefit Level 2 after deductible	You pay 35% after deductible
Allergy Injections and all other injections in a physician's office	$2 per visit after deductible	You pay 35% after deductible
Physical, occupational and speech therapy	Healthy Benefits: - $25 Benefit Level 1 after deductible - $40 Benefit Level 2 after deductible No Healthy Benefits: - $45 Benefit Level 1 after deductible - $60 Benefit Level 2 after deductible	You pay 35% after deductible
Chiropractic care (neuromusculo-skeletal conditions only)	Healthy Benefits: $40 after deductible No Healthy Benefits: $60 after deductible	You pay 35% after deductible 20 visits per calendar year
Mental health care	Healthy Benefits: $25 after deductible No Healthy Benefits: $45 after deductible	You pay 35% after deductible
Chemical health care	Healthy Benefits: $25 after deductible No Healthy Benefits: $45 after deductible	You pay 35% after deductible
Convenience Care		
Convenience clinics (retail clinics), eVisits; if using Virtuwell the first three visits free	Healthy Benefits: $10 after deductible No Healthy Benefits: $20 after deductible	You pay 35% after deductible
Outpatient Care		
Scheduled outpatient procedure	Benefit Level 1 - $125 per year after deductible Benefit Level 2 - $275 per year after deductible	You pay 35% after deductible
Outpatient MRI and CT Scan	You pay 20% after deductible	You pay 35% after deductible
Emergency Care		
Urgently needed care at an urgent care clinic or medical center	Healthy Benefits: $40 after deductible No Healthy Benefits: $60 after deductible	HealthPartners in-network benefit
Emergency care at a hospital ER	$100 co-payment per visit after deductible	HealthPartners in-network benefit
Ambulance	You pay 20% after deductible	HealthPartners in-network benefit

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Plan highlights Partial listing of covered services	In-network Care from a network provider	Out-of-network Care from an out-of-network provider
Inpatient Hospital Care		
Illness or injury, mental and chemical health care	$125 for Benefit Level 1 per admit after deductible $275 for Benefit Level 2 per admit after deductible	You pay 35% after deductible
Durable Medical Equipment		
Durable medical equipment and prosthetic devices	You pay 20% after deductible	You pay 35% after deductible
Home Health Care		
Physical, speech, occupational and respiratory therapy and home health aides	Healthy Benefits: $40 after deductible No Healthy Benefits: $60 after deductible 120 visits per calendar year after deductible	You pay 35% after deductible 60 visits per calendar year
Prescription Drugs **(30-day supply; 1 cycle of oral contraceptives; 90-day supply for mail order)**	**HealthPartners Participating Pharmacy Benefit**	**Non- Participating Pharmacy Benefit**
Retail Pharmacy Co-payment for one-month supply		
- Generic Preferred	$12 co-payment	You pay 35% after deductible
- Brand Preferred	$35 co-payment	You pay 35% after deductible
HealthPartners Mail Order Pharmacy Co-payment for three-month supply		
- Generic Preferred	$24 co-payment	N/A
- Brand Preferred	$70 co-payment	N/A
Specialty Drugs	You pay 20% up to $200 maximum per prescription per month	You pay 35% after deductible
Note: There is a $3,000 annual maximum for Infertility Drugs (Plan covers up to $5,000 worth of charges)		
Benefit Level Coinsurance		
Coinsurance means you pay a portion of the bill for services. The facility you use will decide the format of your bill. Some facilities bill for ALL services provided during your visit (or hospital stay). When you receive one total bill, you will be charged at the facility Benefit Level. For facilities that do not bill for all services in one total bill, you will receive separate bills from each professional who provided services. The individual provider Benefit Level determines the amount you pay.		
2020 Benefits Summary		

THIS PLAN MAY NOT COVER ALL YOUR HEALTH CARE EXPENSES.
READ YOUR GROUP MEMBERSHIP CONTRACT OR SUMMARY PLAN DESCRIPTION CAREFULLY TO DETERMINE WHICH EXPENSES ARE COVERED.
For details about benefits and services, call Member Services at (952) 883-5000 or (800) 883-2177.