

HealthPartners DistinctionsSM II

Ramsey County 2016

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	In-network	Out-of-network
Partial listing of covered services	Care from a network provider	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	<u>Healthy Benefits:</u> - \$20 Benefit Level 1 - \$35 Benefit Level 2 <u>No Healthy Benefits:</u> - \$40 Benefit Level 1 - \$55 Benefit Level 2	You pay 35% after deductible
Allergy Injections	100% coverage	You pay 35% after deductible
Physical, occupational and speech therapy	<u>Healthy Benefits:</u> - \$20 Benefit Level 1 - \$35 Benefit Level 2 <u>No Healthy Benefits:</u> - \$40 Benefit Level 1 - \$55 Benefit Level 2	You pay 35% after deductible
Chiropractic care (neuromusculo-skeletal conditions only)	Healthy Benefits: \$35 No Healthy Benefits: \$55	You pay 35% after deductible 20 visits per calendar year
Mental health care	Healthy Benefits: \$20 No Healthy Benefits: \$40	You pay 35% after deductible
Chemical health care	Healthy Benefits: \$20 No Healthy Benefits: \$40	You pay 35% after deductible
Convenience Care		
Convenience clinics (retail clinics), eVisits; if using Virtuwell the first three visits free	Healthy Benefits: \$10 No Healthy Benefits: \$20	You pay 35% after deductible
Outpatient Care		
Scheduled outpatient procedure	Benefit Level 1 - \$125 per year Benefit Level 2 - \$275 per year	You pay 35% after deductible
Outpatient MRI and CT Scan	You pay 20%	You pay 35% after deductible
Emergency Care		

Urgently needed care at an urgent care clinic or medical center	Healthy Benefits: \$35 No Healthy Benefits: \$55	HealthPartners in-network benefit
Emergency care at a hospital ER	\$100 co-payment per visit	HealthPartners in-network benefit
Ambulance	You pay 20%	HealthPartners in-network benefit

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Partial listing of covered services	Care from a network provider	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 \$275 for Benefit Level 2 per admit	You pay 35% after deductible
Durable Medical Equipment		
Durable medical equipment and prosthetic devices	You pay 20%	You pay 35% after deductible
Home Health Care		
Physical, speech, occupational and respiratory therapy and home health aides	Healthy Benefits: \$35 No Healthy Benefits: \$55 120 visits per calendar year	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 \$3,000 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.		
2016 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.**