Park Nicollet Health Services

January 1, 2012

Partial Listing of Covered Services	Tier 1 Park Nicollet Providers and Referrals	Tier 2 Other Network Providers	Tier 3 Care from an out-of-network provider
Lifetime Maximum Benefits	Unlimited		
Calendar Year Deductible ***Deductible applies except where noted***	$500 per person; $1,000 per family	$750 per person; $1,500 per family	$1,000 per person; $2,000 per family
Cal Year Out-of-Pocket Max (Medical)	$2,000/$3,500	$2,500/$5,000	$3,500/$8,500
Cal Year Out-of-Pocket Maximum (RX)	$2.000/$2,500	$2.000/$2,500	$2.000/$2,500
Preventive Health Care	100% coverage	100% coverage	No coverage
Office Visits	You pay $25 after deductible	You pay $30 after deductble, then 90%	You pay $50 after deductible then 60%
E Visits	You pay $10 after deductible	You pay $10 after deductible then 90%	No Coverage
Urgent Care	You pay $25 after deductible	You pay $30 after deductible then 90%	You pay $50 after deductible then 60%
Emergency Room	100% coverage	100% coverage	100% coverage
Emergency Physician	100% coverage	100% coverage	100% coverage
Inpatient Hospital Methodist, St. Francis, Fairview Ridges	You pay $25 after deductible then 100%	n/a	n/a
All other Hospitals	n/a	You pay $550 after deductible then 90%	You pay $600 after deductible then 60%
Specialty Drugs *Formulary only*	$100 copay		N/A
Retail Pharmacy *Deductible does not apply* *Up to a 31-day supply for medications received at a network pharmacy*	<u>You Pay</u>: Generic Preferred: $10 or 30% to $25 max Brand Preferred: $25 or 30% to $45 max Non Formulary : No coverage	<u>You Pay</u>: Generic Preferred: $20 or 30% to $35 max Brand Preferred: $35 or 30% to $55 max Non Formulary : No coverage	<u>You Pay</u>: 60% 60% Non Formulary:No coverage
Mail Order Prescriptions *Up to a 93-day supply for medications received by mail from the designated mail service prescription drug program.*	<u>You Pay</u>: Generic Preferred: $75 Brand Preferred: $135 Non Formulary : No Coverage		N/A

NOTE: * Coverage is limited to the non-network provider reimbursement amount (as defined in your Plan Document) after deductible is met.

Summary of utilization management programs

HealthPartners utilization management programs help ensure effective, accessible and high quality health care. These programs are based on the most up-to-date medical evidence to evaluate appropriate levels of care and establish guidelines for medical practices. Our programs include activities to reduce the underuse, overuse and misuse of health services. These programs include:

- Inpatient concurrent review and care coordination to support timely care and ensure a safe and timely transition from the hospital
- "Best practice" care guidelines for selected kinds of care
- Outpatient case management to provide care coordination
- The CareCheck® program to coordinate out-of-network hospitalizations and certain services.

We require prior approval for a small number of services and procedures. For a complete list, go to **healthpartners.com** or call Member Services. You must call CareCheck® at (952) 883-5800 or 1-800-942-4872 to receive maximum benefits when using out-of-network providers for in-patient hospital stays; same-day surgery; new or experimental or reconstructive outpatient technologies or procedures; durable medical equipment or prosthetics costing more than $3,000; home health services after your visits exceed 30; and skilled nursing facility stays. We will review your proposed treatment plan, determine length of stay, approve additional days when needed and review the quality and appropriateness of the care you receive. Benefits will be reduced by 20 percent if CareCheck® is not notified.

Our approach to protecting personal information

HealthPartners complies with federal and state laws regarding the confidentiality of medical records and personal information about our members and former members. Our policies and procedures help ensure that the collection, use and disclosure of information complies with the law. When needed, we get consent or authorization from our members (or an approved member representative when the member is unable to give consent or authorization) for release of personal information. We give members access to their own information consistent with applicable law and standards. Our policies and practices support appropriate and effective use of information, internally and externally, and enable us to serve and improve the health of our members, our patients and the community, while being sensitive to privacy. For a copy of our privacy notice, please visit **healthpartners.com** or call Member Services at 952-883-5000 or 1-800-883-2177. Please contact your provider for a copy of the HealthPartners privacy notice.

Appropriate use and coverage of prescription medications

We provide our members with coverage for high quality, safe and cost-effective medications. To help us do this, we use:

- A preferred list of prescription drugs that has been reviewed and approved for coverage based on quality, safety, effectiveness and value.
- A special program that helps members who use many different medications avoid unintended drug interactions.

The preferred drug list is available on **healthpartners.com**, along with information on how drugs are reviewed, the criteria used to determine which drugs are added to the list, and more. You may also get this information from Member Services.

Services not covered

After you enroll, you will receive a Plan Document that explains exact coverage terms and conditions. *This plan does not cover all health care expenses*. In general, services not provided or directed by a licensed physician are not covered. The following is a *summary* of excluded or limited items:

- Treatment, services or procedures which are experimental, investigative or are not medically necessary
- Dental care or oral surgery†
- Non-rehabilitative chiropractic services
- Eyeglasses, contact lenses, hearing aids and their fittings
- Private-duty nursing; rest, respite and custodial care†
- Cosmetic surgery†
- Vocational rehabilitation; recreational or educational therapy
- Sterilization reversal and artificial conception processes†
- Physical, mental or substance-abuse examinations done for, or ordered by third parties†
- Out-of-network coverage may also exclude preventive health care services

† *except as specifically described in your Group Membership Contract or Summary Plan Description.*

Grandfathered plan

HealthPartners believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at **(952) 883-5000 or 1-800-883-2177.** You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866–444–3272 or **dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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