

NationalONESM Copay Plans
2009 Wisconsin Small Employer Product Comparison

HEALTH SERVICE	\$20-100%	
	In Network	Out of Network
Lifetime maximum	\$3,000,000 combined in and out of network	
Annual deductible	No deductible	\$ 300 per person; \$600 per family
Annual out-of-pocket maximum	\$1,500 per person; \$3,000 per family	\$2,750 per person; \$5,500 per family
Preventive health care	\$20 copayment	60% coverage after deductible
Office visits	\$20 copayment	60% coverage after deductible
Convenience Care	\$10 copayment	60% coverage after deductible
Inpatient hospital care	100% coverage	60% coverage after deductible
Outpatient care	100% coverage	60% coverage after deductible
Outpatient MRI and CT	100% coverage	60% coverage after deductible
Emergency care		
Urgent care center	\$20 copayment	60% coverage after deductible
Hospital ER	\$100 copayment	60% coverage after deductible
Prescriptions	\$12 Generic Preferred \$35 Brand Preferred \$50 Nonpreferred Specialty: 80% up to \$200 OOP max per prescription Infertility: \$3,000 annual maximum	60% coverage after deductible
HealthPartners Mail Order Pharmacy	\$24 Generic Preferred / \$70 Brand Preferred / \$100 Nonpreferred; up to a 93-day supply	
Pre-existing condition limitation	Pre-existing condition limitation applies in the first 12 months of coverage (18 months for late entrants) on all conditions existing within 6 months prior to the effective date of coverage under this plan.	
<p>This is a general product comparison for employer use only; it is not intended for employee presentation. For a complete summary of benefits, contact your sales representative. The products listed may not cover all of your employees' health care expenses. For exact terms and conditions, refer to a Group Certificate to determine which expenses are covered.</p> <p>Fully insured Wisconsin plans are underwritten and administered by HealthPartners Insurance Company.</p>		

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HEALTH SERVICE	\$25-80%		\$35-80%	
	In Network	Out of Network	In Network	Out of Network
Lifetime maximum	\$3,000,000 combined in and out of network		\$3,000,000 combined in and out of network	
Annual deductible	No deductible	\$300 per person; \$600 per family	No deductible	\$300 per person; \$600 per family
Annual out-of-pocket maximum	\$1,500 per person; \$3,000 per family	\$2,750 per person; \$5,500 per family	\$2,000 per person; \$4,000 per family	\$3,750 per person; \$7,500 per family
Preventive health care	\$20 copayment	60% coverage after deductible	\$20 copayment	60% coverage after deductible
Office visits	\$20 copayment	60% coverage after deductible	\$20 copayment	60% coverage after deductible
Inpatient hospital care	100% coverage	60% coverage after deductible	90% coverage	60% coverage after deductible
Outpatient care	100% coverage	60% coverage after deductible	90% coverage	60% coverage after deductible
Outpatient MRI and CT	100% coverage	60% coverage after deductible	90% coverage	60% coverage after deductible
Emergency care				
Urgent care center	\$20 copayment	60% coverage after deductible	\$20 copayment	60% coverage after deductible
Hospital ER	\$100 copayment	60% coverage after deductible	\$100 copayment	60% coverage after deductible
Prescriptions	\$12 Generic Preferred \$35 Brand Preferred \$50 Nonpreferred Specialty: 80% up to \$200 OOP max per prescription	60% coverage after deductible	\$12 Generic Preferred \$35 Brand Preferred \$50 Nonpreferred Specialty: 80% up to \$200 OOP max per prescription	60% coverage after deductible
HealthPartners Mail Order Pharmacy	\$24 Generic Preferred / \$70 Brand Preferred / \$100 Nonpreferred; up to a 93-day supply		\$24 Generic Preferred / \$70 Brand Preferred / \$100 Nonpreferred; up to a 93-day supply	
Pre-existing condition limitation	Pre-existing condition limitation applies in the first 12 months of coverage (18 months for late entrants) on all conditions existing within 6 months prior to the effective date of coverage under this plan.			
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Effective July 1, 2009