

NationalONESM Copay Plans
2010 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 |
| 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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| 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 | \$35 copayment | 60% coverage after deductible |
| Office visits | \$20 copayment | 60% coverage after deductible | \$35 copayment | 60% coverage after deductible |
| Inpatient hospital care | 80% coverage | 60% coverage after deductible | 80% coverage | 60% coverage after deductible |
| Outpatient care | 80% coverage | 60% coverage after deductible | 80% coverage | 60% coverage after deductible |
| Outpatient MRI and CT | 80% coverage | 60% coverage after deductible | 80% coverage | 60% coverage after deductible |
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