



Donaldson 2010 Summary of Benefits

The following provides an overview of your HealthPartners coverage. For exact coverage details consult a Group Membership Contract or Summary Plan Description or call Member Services at 952-883-5000 or 1-800-883-2177.

Medical Plan Highlights Partial listing of covered services	HSA Plan		Traditional Plan- Enhanced (Completed Health Assessment)		Traditional Plan- Basic (w/o Health Assessment)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible and Out-of-Pocket						
Lifetime Maximum- combined all Donaldson plans	\$1,000,000		\$1,000,000		\$1,000,000	
Calendar Plan year deductible	\$1,200 Individual; \$2,400 Family	\$2,400 Individual; \$4,800 Family	\$500 Individual; \$1,000 Family	\$1,000 Individual; \$2,000 Family	\$750 Individual; \$1,500 Family	\$1,500 Individual; \$3,000 Family
	\$250 contribution to HSA by Donaldson if employee completes Health Assessment					
Calendar Plan year medical out-of-pocket maximum	\$4,000 Individual; \$8,000 Family	\$8,000 Individual; \$10,000 Family	\$3,500 Individual; \$7,000 Family	\$4,000 Individual; \$8,000 Family	\$3,750 Individual; \$7,500 Family	\$4,500 Individual; \$9,000 Family
Preventive Healthcare						
Routine physical and eye examinations	100% coverage	100% coverage	100% coverage	100% coverage	100% coverage	100% coverage
Prenatal and postnatal care	80% coverage	60% coverage	100% coverage	70% after ded.	100% coverage	70% after ded.
Immunizations	100% coverage	100% coverage	100% coverage	100% coverage	100% coverage	100% coverage
Office Visits						
Illness or injury	80% after ded.	60% after ded.	90% after ded. *	70% after ded.	90% after ded. *	70% after ded.
Allergy Injections	80% after ded.	60% after ded.	90% after ded.	70% after ded.	90% after ded.	70% after ded.
Physical, occupational and speech therapy	80% after ded.	60% after ded.	90% after ded.	70% after ded.	90% after ded.	70% after ded.
Chiropractic care (for neuromusculo-skeletal conditions only)	80% after ded.	60% after ded.	90% after ded.	70% after ded.	90% after ded.	70% after ded.
Mental health care/Chemical health	80% after ded.	60% after ded.	90% after ded.	70% after ded.	90% after ded.	70% after ded.
Emergency Care						
Urgently needed care at an urgent care clinic or medical center	80% after ded.	60% after ded.	90% after ded. *	70% after ded.	90% after ded. *	70% after ded.
Emergency care at a hospital ER	80% after ded.	60% after ded.	90% after ded.	70% after ded.	90% after ded.	70% after ded.
Ambulance	80% after ded.	60% after ded.	90% after ded.	70% after ded.	90% after ded.	70% after ded.
Inpatient Hospital Care						
Illness or injury	80% after ded.	60% after ded.	90% after ded.	70% after ded.	90% after ded.	70% after ded.
Mental health care	80% after ded.	60% after ded.	90% after ded.	70% after ded.	90% after ded.	70% after ded.
Chemical health care	80% after ded.	60% after ded.	90% after ded.	70% after ded.	90% after ded.	70% after ded.
Outpatient Care						
Scheduled outpatient procedures	80% after ded.	60% after ded.	90% after ded.	70% after ded.	90% after ded.	70% after ded.
Outpatient MRI and CT	80% after ded.	60% after ded.	90% after ded.	70% after ded.	90% after ded.	70% after ded.
Durable Medical Equipment						
Durable Medical Equipment and prosthetic devices	80% after ded.	60% after ded.	90% after ded.	70% after ded.	90% after ded.	70% after ded.
Pharmacy Highlights						
Partial listing of covered services	Plan 1		Plan 2		Plan 3	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Retail Pharmacy (up to a 30-day supply or one cycle of oral contraceptives)						
Generic preferred	80% after ded.	60% after ded.	\$7 Copay	70% after ded.	\$7 Copay	70% after ded.
Brand preferred	80% after ded.	60% after ded.	80% (Minimum \$25; Maximum \$50)	70% after ded.	80% (Minimum \$25; Maximum \$50)	70% after ded.
Non-preferred	80% after ded.	60% after ded.	80% (Minimum \$50; Maximum \$75)	70% after ded.	80% (Minimum \$50; Maximum \$75)	70% after ded.
HealthPartners Mail Order Pharmacy (up to a 90-day supply)						
Generic preferred	80% after ded.	No Coverage	\$14 Copay	No coverage	\$14 Copay	No coverage
Brand preferred	80% after ded.	No Coverage	80% (Minimum \$60; Maximum \$125)	No coverage	80% (Minimum \$60; Maximum \$125)	No coverage
Non-preferred	80% after ded.	No Coverage	80% (Minimum \$125; Maximum \$180)	No coverage	80% (Minimum \$125; Maximum \$180)	No coverage

*first two visits covered 100%, ded. does not apply