ALLINA Hospitals & Clinics

Administered by HealthPartners

Allina Hospitals & Clinics
Plus Plan
(Noncontract Standard Pharmacy Option)
2011 Benefit Summary

The following provides an overview of the Allina Plus plan. For exact coverage details consult the Summary Plan Description or call HealthPartners Member Services at 952-883-7300 or 1-877-822-6706.

Medical Plan Highlights	**Plus Plan**	
Partial listing of covered services	**In-Network**	**Out-of-Network**
Deductible and Maximum		
Calendar year deductible	None	$300 per person, up to a maximum of $600 per family
Calendar year medical out-of-pocket maximum	None	$1,300 per person, up to a maximum of $2,600 per family
Preventive Health Care		
Routine physical, eye examinations and well child visits	$0	No coverage
Preventive lab and pathology	$0	No coverage
Prenatal and postnatal care	$0	Deductible, then 20%
Immunizations	$0	No coverage
Office Visits		
Illness or injury	$0	Deductible, then 20%
Allergy injections	$0	No coverage
Physical, occupational and speech therapy	$0	Deductible, then 20%
Chiropractic care	$0	Deductible, then 20%
Mental health care	$0	Deductible, then 20%
Chemical health care	$0	Deductible, then 20%
Emergency Care		
Urgently needed care at an urgent care clinic or medical center	$0	Deductible, then 20%
Emergency care at a hospital ER	$25 copay	$25 copay, then 20%
Ambulance	20%	20%
Inpatient Hospital Care		
Illness or injury	$150 copay per stay Limited to 4 $150 copays per year. $0 at Allina designated facility.	Deductible, then 20%
Mental health care	$0	Deductible, then 20%
Chemical health care	$0	Deductible, then 20%
Outpatient Care		
Other scheduled outpatient services	$0	Deductible, then 20%
Outpatient lab and pathology	$0	Deductible, then 20%
Outpatient MRI and CT	$0	Deductible, then 20%
Durable Medical Equipment		
Durable medical equipment and prosthetic devices	$0	Deductible, then 20%

Pharmacy Plan Highlights	**Plus Plan**	
Partial listing of covered services	**In-Network**	**Out-of-Network**
Retail Pharmacy		
Generic	$10 copay	Deductible, then 40%
Brand preferred	$35 copay	Deductible, then 40%
Non-preferred	50%	Deductible, then 60%
Retail Days Supply	31 days	
Mail Order Pharmacy - Allina Community Pharmacy Only		
Generic	$25 copay	No coverage
Brand preferred	$90 copay	No coverage
Non-preferred	40%	No coverage
Mail Order Pharmacy Days Supply	93 days	

Allina considers this medical plan a "grandfathered health plan" under the Patient Protection and Affordable Care Act. Please refer to the Summary Plan Description for additional information.