Allina Hospitals & Clinics

2012 Benefit Summary

The following provides an overview of the Allina MNA Plans with the Allina First Pharmacy Benefit.
For exact coverage details consult a Summary Plan Description or call HealthPartners Member Services at 952-883-7300 or 1-877-822-6706.

	Allina MNA Plans with Allina First Pharmacy Benefit						
Medical Plan Highlights Partial listing of covered services	**250 Plan**		**Choice Plan**		**Plus Plan**		**Advantage Plan**
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**
Deductible and Maximum							
Calendar year deductible	$250 per person, up to a maximum of $500 per family	$500 per person, up to a maximum of $1,000 per family	None	$300 per person, up to a maximum of $900 per family	None	$300 per person, up to a maximum of $600 per family	None
Calendar year medical out-of-pocket maximum	$1,250 per person, up to a maximum of $2,500 per family	$2,000 per person, up to a maximum of $4,000 per family	$3,000 per person in- and out-of-network combined		None	$1,300 per person, up to a maximum of $2,600 per family	$500 per person, up to a maximum of $1,000 per family
Annual maximum for medical and pharmacy essential benefits	$2,000,000 per person combined across all plans						
Preventive Health Care							
Routine physical, eye examinations and well child visits	$0	No coverage	$0	No coverage for routine physicals; 20% for eye exams and well child visits.	$0	No coverage	$0
Preventive lab and pathology	$0	No coverage	$0	No coverage	$0	No coverage	$0
Prenatal and postnatal care	$0	Deductible, then 30%	$0	Deductible, then 20%	$0	Deductible, then 20%	$0
Immunizations	$0	No coverage	$0	Deductible, then 20%	$0	No coverage	$0
Office Visits							
Illness or injury	Deductible, then 20%	Deductible, then 30%	$15 copay	Deductible, then 20%	$0	Deductible, then 20%	$15 copay
Allergy injections	10%	No coverage	$0	Deductible, then 20%	$0	No coverage	$0
Physical, occupational and speech therapy	Deductible, then 20%	Deductible, then 30%	$15 copay	Deductible, then 20%	$0	Deductible, then 20%	$15 copay
Chiropractic care	Deductible, then 20%	Deductible, then 30%	$15 copay	Deductible, then 20%	$0	Deductible, then 20%	$15 copay
Mental health care	Deductible, then 20%	Deductible, then 30%	$15 copay	Deductible, then 20%	$0	Deductible, then 20%	$15 copay
Chemical health care	Deductible, then 20%	Deductible, then 30%	$15 copay	Deductible, then 20%	$0	Deductible, then 20%	$15 copay

Allina MNA Plans with Allina First Pharmacy Benefit							
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Emergency Care							
Urgently needed care at an urgent care clinic or medical center	Deductible, then 20%	Deductible, then 30%	$15 copay	Deductible, then 20%	$0	Deductible, then 20%	$15 copay
Emergency care at a hospital ER	$25 copay per visit, deductible, then 20% (copay waived if admitted within 24 hours)		$40 copay per visit (waived if admitted within 24 hours)		$25 copay per visit (waived if admitted within 24 hours)		$25 copay
Ambulance	20%	20%	20%, up to a maximum of $500 per calendar year	20%, up to a maximum of $500 per calendar year	20%	20%	20%
Inpatient Hospital Care							
Illness or injury	$150 copay per stay, deductible, then 20%, Limited to 4 $150 copays per year. (Copay waived at Allina-designated facilities.)	Deductible, then 30%	$150 copay per stay Limited to 4 $150 copays per year. $0 at Allina designated facility.	Deductible, then 20%	$150 copay per stay Limited to 4 $150 copays per year. $0 at Allina designated facility.	Deductible, then 20%	$0
Mental health care	Deductible, then 20%	Deductible, then 30%	$0	Deductible, then 20%	$0	Deductible, then 20%	$0
Chemical health care	Deductible, then 20%	Deductible, then 30%	$0	Deductible, then 20%	$0	Deductible, then 20%	$0
Outpatient Care							
Other scheduled outpatient services	Deductible, then 20%	Deductible, then 30%	$15 copay	Deductible, then 20%	$0	Deductible, then 20%	$15 copay
Outpatient lab and pathology	Deductible, then 20%	Deductible, then 30%	$0	Deductible, then 20%	$0	Deductible, then 20%	$0
Outpatient MRI and CT	Deductible, then 20%	Deductible, then 30%	$0	Deductible, then 20%	$0	Deductible, then 20%	$0
Durable Medical Equipment							
Durable medical equipment and prosthetic devices	Deductible, then 20%	Deductible, then 30%	20%	Deductible, then 20%	$0	Deductible, then 20%	$0

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	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	
Pharmacy Plan Highlights Partial listing of covered services	**Allina Community Pharmacies**	**Broad Access Network**	**Allina Community Pharmacies**	**Broad Access Network**	**Allina Community Pharmacies**	**Broad Access Network**	**Allina Community Pharmacies**	**Broad Access Network**
Retail Pharmacy (up to a 31-day supply or one cycle of oral contraceptives)								
Generic	$0	$8 copay	$0	$8 copay	$0	$8 copay	$0	$8 copay
Brand preferred	25%	40%	25%	40%	25%	40%	25%	40%
Non-preferred	50%	60%	50%	60%	50%	60%	50%	60%
Specialty	$0 generic; 25% brand preferred; 50% non-preferred	$8 generic; 40% brand preferred; 60% non-preferred *HealthPartners Designated Vendor Only*	$0 generic; 25% brand preferred; 50% non-preferred	$8 generic; 40% brand preferred; 60% non-preferred *HealthPartners Designated Vendor Only*	$0 generic; 25% brand preferred; 50% non-preferred	$8 generic; 40% brand preferred; 60% non-preferred *HealthPartners Designated Vendor Only*	$0 generic; 25% brand preferred; 50% non-preferred	$8 generic; 40% brand preferred; 60% non-preferred *HealthPartners Designated Vendor Only*
Mail Order (93 day supply)	$0 generic; 25% brand preferred; 50% non-preferred	No coverage	$0 generic; 25% brand preferred; 50% non-preferred	No coverage	$0 generic; 25% brand preferred; 50% non-preferred	No coverage	$0 generic; 25% brand preferred; 50% non-preferred	No coverage
Pharmacy out-of-pocket maximum	$1,000	No maximum	$1,000	No maximum	$1,000	No maximum	$1,000	No maximum