



The following is a general outline of the coverage that would be provided by this plan. Exact coverage terms and conditions will be set forth in the plan.

Plan highlights	In-network: Open Access	Out-of-Network
Partial listing of covered services	Care from a network provider	Care from an out-of-network provider
Deductibles and Out-of-Pocket Limits		
Lifetime maximum	Unlimited	Unlimited
Calendar year individual deductible - Traditional (Embedded)	\$250	\$500
Calendar year family deductible - Traditional (Embedded)	\$500	\$1,000
Calendar year individual out-of-pocket limit - Traditional (Embedded)	\$750	\$2,000
Calendar year family out-of-pocket limit - Traditional (Embedded)	\$1,500	\$4,000
Calendar year separate individual out-of-pocket limit for pharmacy services	\$6,600	
Calendar year separate family out-of-pocket limit for pharmacy services	\$13,200	
Preventive Health Care		
Routine physical exams	100%	70% after deductible
Routine eye exams	100%	70% after deductible
Postnatal care	100%	70% after deductible
Prenatal care	100%	70% after deductible
Well-child care	100%	70% after deductible
Immunizations	100%	100%
Office Visits		
Illness or injury	90% after deductible	70% after deductible
Mental health	90% after deductible	70% after deductible
Chemical health	90% after deductible	70% after deductible
Physical, occupational & speech therapy	90% after deductible	70% after deductible
Chiropractic care	90% after deductible	70% after deductible
Allergy injections	90% after deductible	70% after deductible
Convenience Care		
Convenience clinics (retail clinics)	90% after deductible	70% after deductible
E-visits	90% after deductible	70% after deductible
virtuwell	90% after deductible	Not covered
Free Visits		
Free visits for virtuwell only	3	None
Emergency Care		
Urgently needed care at an urgent care clinic or medical center	90% after deductible	Same as in-network benefit
Emergency care at a hospital emergency room	90% after deductible	Same as in-network benefit
Ambulance	90% after deductible	Same as in-network benefit
Inpatient Hospital Care		
Illness or injury	90% after deductible	70% after deductible
Mental health	90% after deductible	70% after deductible
Chemical health	90% after deductible	70% after deductible



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Plan highlights	In-network: Open Access	Out-of-Network
Outpatient Care		
Scheduled outpatient procedures	90% after deductible	70% after deductible
Outpatient MRI and CT scan	90% after deductible	70% after deductible
Durable Medical Equipment		
Durable medical equipment & prosthetics	90% after deductible	70% after deductible
Diagnostic Imaging		
Preventive diagnostic imaging	100%	70% after deductible
Non-preventive diagnostic imaging	90% after deductible	70% after deductible
Lab Services		
Preventive lab services	100%	70% after deductible
Non-preventive lab services	90% after deductible	70% after deductible
Pharmacy PreferredRx formulary 30-day supply; 90-day supply mail order	<i>Pharmacy benefits do not include all drug classes. See plan materials for additional information.</i>	
Retail	Participating Pharmacies	Non-Participating Pharmacies
Retail generic formulary	\$5 copay	70% after deductible
Retail brand formulary	\$20 copay	70% after deductible
Retail generic non-formulary	\$50 copay	70% after deductible
Retail brand non-formulary	\$50 copay	70% after deductible
Mail order	Participating Pharmacies	Non-Participating Pharmacies
Generic formulary from HealthPartners mail order pharmacy	\$10 copay	Not covered
Brand formulary from HealthPartners mail order pharmacy	\$40 copay	Not covered
Generic non-formulary from HealthPartners mail order pharmacy	\$100 copay	Not covered
Brand non-formulary from HealthPartners mail order pharmacy	\$100 copay	Not covered
Specialty	Participating Pharmacies	Non-Participating Pharmacies
Specialty generic formulary	\$5 copay	70% after deductible
Specialty brand formulary	\$20 copay	70% after deductible
Specialty generic non-formulary	\$50 copay	70% after deductible
Specialty brand non-formulary	\$50 copay	70% after deductible
<i>See specialty drug list on healthpartners.com.</i>		