

HealthPartners Open Access Choice Schedule of Payments

Master Contractholder: Lifeworks Services, Inc.

Group Number: 25215

Effective Date: The later of October 1, 2010 and your effective date of coverage under the Master Group Contract.

See the Membership Contract for additional information about covered services and limitations.

The amount that we pay for covered services is listed below. The member is responsible for the specified dollar amount and/or percentage of charges that we do not pay.

HealthPartners Benefits are underwritten by HealthPartners. APN and Non-Network Benefits are underwritten by HealthPartners Insurance Company. The HealthPartners Benefits constitute a comprehensive plan. The APN and Non-Network Benefits constitute non-qualified plans.

In HealthPartners Open Access Choice, you have direct access to any HealthPartners network providers listed in the HealthPartners Open Access Network provider directory.

Coverage may vary depending on whether you select a HealthPartners provider, APN Network provider or a Non-network provider.

These definitions apply to the Schedule of Payments. They also apply to the Contract.

Charge: For covered services delivered by participating network providers, is the provider's discounted charge for a given medical/surgical service, procedure or item.

For covered services delivered by non-network providers, is the provider's charge for a given medical/surgical service procedure or item, according to the usual and customary charge allowed amount.

The Usual and Customary Charge is the maximum amount allowed we consider in the calculation of payment of charges incurred for certain covered services. It is consistent with the charge of other providers of a given service or item in the same region.

A charge is incurred for covered ambulatory medical and surgical services, on the date the service or item is provided. A charge is incurred for covered inpatient services, on the date of admission to a hospital. To be covered, a charge must be incurred on or after the member's effective date and on or before the termination date.

Combined Day Limit: Your total benefit is combined, for inpatient hospitalization, skilled nursing facility care services and inpatient mental and chemical health services, and limited to 365 days per period of confinement. Each day of such services provided under the HealthPartners Benefits, APN Benefits and Non-Network Benefits counts toward this combined day limit, for the same period of confinement.

Copayment/Coinsurance: The specified dollar amount, or percentage, of charges incurred for covered services, which we do not pay, but which a member must pay, each time a member receives certain medical services, procedures or items. Our payment for those covered services or items begins after the copayment or coinsurance is satisfied. Covered services or items requiring a copayment or coinsurance are specified in this Contract.

For services provided by a network provider:

An amount which is listed as a flat dollar copayment is determined by a formula set forth in law which is based on the network provider's retail (undiscounted) charges for that service. However, if the network provider's discounted charge for a service or item is less than the flat dollar copayment, you will pay the network provider's discounted charge. An amount which is listed as a percentage of charges or coinsurance is based on the network provider's discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule rate for case rate or withhold arrangements.

For services provided by a non-network provider:

Any copayment or coinsurance is applied to the lesser of the provider's charges or the usual and customary charge for a service.

A copayment or coinsurance is due at the time a service is provided, or when billed by the provider. The copayment or coinsurance applicable for a scheduled visit with a network provider will be collected for each visit, late cancellation and failed appointment.

Deductible: The specified dollar amount of charges incurred for covered services, which we do not pay, but a member or a family has to pay first in a plan year. Our payment for those services or items begins after the deductible is satisfied. If you have a family deductible, each individual family member may only contribute up to the individual deductible amount toward the family deductible. An individual's copayments and coinsurance do not apply toward the family deductible. For network providers, the amount of the charges that apply to the deductible are based on the network provider's discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule rate for case rate or withhold arrangements. For non-network providers, the amount of charges that apply to the deductible are the lesser of the provider's charges or the usual and customary charge for a service. The Schedule of Payments indicates which covered services are not subject to the deductible.

Lifetime Maximum Benefit: The specified coverage limit paid for all charges combined and actually paid by us for a member under that coverage. Our payment ceases for that member, when that limit is reached. The member has to pay for subsequent charges.

Non-Preferred Drug: This is a prescription drug which is not on the preferred drug list, is medically necessary and is not investigative or otherwise excluded under this Contract.

Out-of-Pocket Expenses: You pay the specified copayments/coinsurance and deductibles applicable for particular services, subject to the out-of-pocket limit described below. These amounts are in addition to the monthly enrollment payments.

Out-of-Pocket Limit: You pay the copayments/coinsurance and deductibles for covered services, to the individual or family out-of-pocket limit. Thereafter we cover 100% of charges incurred for all other covered services, for the rest of the plan year. You pay amounts greater than the out-of-pocket limit if any benefit maximums or the lifetime maximum are exceeded. Non-Network benefits for transplant surgery do not apply to the out-of-pocket limit.

You are responsible to keep track of the out-of-pocket expenses. Contact our Member Services department for assistance in determining the amount paid by the enrollee for specific eligible services received. Claims for reimbursement under the out-of-pocket limit provisions are subject to the same time limits and provisions described under the "Claims Provisions" section of the contract.

Plan Year: Applies to provisions which are based on a plan year. The initial plan year begins at 12:01 A.M. Central Time on the effective date of the group health plan sponsor’s Master Group Contract and ends at 12:00 A.M. of the first anniversary date. Subsequent plan years begin at 12:01 A.M. of the anniversary date and end at 12:00 A.M. of the following anniversary date.

Preferred Drug List: This is a current list, which may be revised from time to time, of preferred prescription drugs, medications, equipment and supplies covered by us as indicated in the Schedule of Payments which are covered at the highest benefit level. Some drugs may require authorization to be covered as preferred drugs. We also have written guidelines and procedures for granting an exception to the preferred drug list that is available to you upon request. These guidelines and procedures include exceptions to the preferred drug list for anti-psychotic prescription drugs prescribed to treat emotional disturbances or mental illness and your right to receive certain non-preferred prescription drugs for diagnosed mental illness or emotional disturbance when our preferred drug list changes or you change health plans. The preferred drug list, and information on drugs that require authorization, are available by calling Member Services, or on our web site at www.healthpartners.com.

Specialty Drug List: This is a current list, which may be revised from time to time, of prescription drugs, medications, equipment and supplies, which are typically bio-pharmaceuticals. The purpose of a specialty drug list is to facilitate enhanced monitoring of complex therapies used to treat specific conditions. Specialty drugs are covered by us as indicated below. The specialty drug list is available by calling Member Services, or on our web site at www.healthpartners.com.

	<u>HealthPartners Benefits</u>	<u>APN Benefits</u>	<u>Non-Network Benefits</u>
Individual Plan Year Deductible	\$300	\$300	\$750
Family Plan Year Deductible	\$600	\$600	\$1,500
<i>Deductibles under the HealthPartners Benefits, APN Benefits and the Non-Network Benefits are combined.</i>			
Individual Plan Year Out-of-Pocket Limit	\$1,500	\$1,500	\$3,000
Family Plan Year Out-of-Pocket Limit	\$5,000	\$5,000	None.
<i>The Out-of-Pocket Limits under the HealthPartners Benefits, APN Benefits and Non-Network Benefits are combined.</i>			
<i>Any reduction in benefits for failure to comply with CareCheck® requirements will not apply toward the Out-of-Pocket Limit.</i>			
Lifetime Maximum Benefit for Transplant Surgery	Unlimited.	Unlimited.	\$25,000
Lifetime Maximum Benefit	Unlimited.	Unlimited.	\$1,000,000

COVERED SERVICES	<u>HealthPartners Benefits</u>	<u>APN Benefits</u>	<u>Non-Network Benefits</u>
A. ACUPUNCTURE	100% of the charges incurred, subject to a member copayment of \$15 per office visit. Deductible does not apply.	100% of the charges incurred, subject to a member copayment of \$15 per office visit. Deductible does not apply.	No Coverage.
B. AMBULANCE AND MEDICAL TRANSPORTATION	80% of the charges incurred.	80% of the charges incurred.	See HealthPartners Benefits.
C. BEHAVIORAL HEALTH			
Mental Health Services			
a. Outpatient Services, including intensive outpatient and day treatment services	100% of the charges incurred, subject to a member copayment of \$15 per visit. Deductible does not apply. For family therapy, only one member copayment will be charged, regardless of the number of members primarily involved in the therapy.	100% of the charges incurred, subject to a member copayment of \$15 per visit. Deductible does not apply. For family therapy, only one member copayment will be charged, regardless of the number of members primarily involved in the therapy.	60% of the charges incurred.
Group Therapy	100% of the charges incurred, subject to a member copayment of \$7.50 per visit. Deductible does not apply.	100% of the charges incurred, subject to a member copayment of \$7.50 per visit. Deductible does not apply.	60% of the charges incurred.
b. Inpatient Services, including psychiatric residential treatment for emotionally handicapped children	See HealthPartners Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.	See APN Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.	See Non-Network Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.

COVERED SERVICES	<u>HealthPartners Benefits</u>	<u>APN Benefits</u>	<u>Non-Network Benefits</u>
Chemical Health Services			
a. Outpatient Services, including intensive outpatient and day treatment services	100% of the charges incurred, subject to a member copayment of \$15 per visit. Deductible does not apply. For family therapy, only one member copayment will be charged, regardless of the number of members primarily involved in the therapy. We cover supervised lodging at a contracted organization for members actively involved in an affiliated licensed chemical dependency day treatment or intensive outpatient program for treatment of alcohol or drug abuse.	100% of the charges incurred, subject to a member copayment of \$15 per visit. Deductible does not apply. For family therapy, only one member copayment will be charged, regardless of the number of members primarily involved in the therapy. We cover supervised lodging at a contracted organization for members actively involved in an affiliated licensed chemical dependency day treatment or intensive outpatient program for treatment of alcohol or drug abuse.	60% of the charges incurred.
b. Inpatient Services	See HealthPartners Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.	See APN Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.	See Non-Network Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.
D. CHIROPRACTIC SERVICES	100% of the charges incurred, subject to a member copayment of \$15 per office visit. Deductible does not apply.	100% of the charges incurred, subject to a member copayment of \$15 per office visit. Deductible does not apply.	60% of the charges incurred. Limit of 20 visits per plan year.
E. DENTAL SERVICES			
Accidental Dental Services			
a. Accidental Dental Services Within the Network	80% of the charges incurred.	80% of the charges incurred.	No Coverage.
b. Emergency Accidental Dental Services Outside the Network	Subject to a maximum benefit of \$300 per plan year, 75% of the charges incurred.	See HealthPartners Benefits.	See HealthPartners Benefits.
<i>For all accidental dental services, treatment and/or restoration must be initiated within six months of the date of the injury. Coverage is limited to the initial course of treatment and/or initial restoration. Services must be provided within twenty-four months of the date of injury to be covered.</i>			

COVERED SERVICES	<u>HealthPartners Benefits</u>	<u>APN Benefits</u>	<u>Non-Network Benefits</u>
Medical Referral Dental Services			
a. Medically Necessary Outpatient Dental Services	100% of the charges incurred, subject to a member copayment of \$15 per office visit. Deductible does not apply.	100% of the charges incurred, subject to a member copayment of \$15 per office visit. Deductible does not apply.	60% of the charges incurred.
b. Medically Necessary Hospitalization and Anesthesia for Dental Care	See HealthPartners Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.	See APN Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.	See Non-Network Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.
c. Medical Complications of Dental Care	100% of the charges incurred, subject to a member copayment of \$15 per office visit. Deductible does not apply.	100% of the charges incurred, subject to a member copayment of \$15 per office visit. Deductible does not apply.	60% of the charges incurred.
Oral Surgery	100% of the charges incurred, subject to a member copayment of \$15 per office visit. Deductible does not apply.	100% of the charges incurred, subject to a member copayment of \$15 per office visit. Deductible does not apply.	60% of the charges incurred.
Orthognathic Surgery Benefit	75% of the charges incurred.	75% of the charges incurred.	No Coverage.
Treatment of Cleft Lip and Cleft Palate of a Dependent Child	100% of the charges incurred, subject to a member copayment of \$15 per office visit. Deductible does not apply.	100% of the charges incurred, subject to a member copayment of \$15 per office visit. Deductible does not apply.	60% of the charges incurred.
Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD)	100% of the charges incurred, subject to a member copayment of \$15 per office visit. Deductible does not apply.	100% of the charges incurred, subject to a member copayment of \$15 per office visit. Deductible does not apply.	60% of the charges incurred.

COVERED SERVICES	<u>HealthPartners Benefits</u>	<u>APN Benefits</u>	<u>Non-Network Benefits</u>
F. DIAGNOSTIC IMAGING SERVICES			
<i>We cover services provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)</i>			
associated with covered preventive services (MRI/CT procedures are not considered preventive)	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	60% of the charges incurred.
for illness or injury			
(a) Outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT)	80% of the charges incurred.	80% of the charges incurred.	60% of the charges incurred.
(b) All other outpatient diagnostic imaging services	80% of the charges incurred.	80% of the charges incurred.	60% of the charges incurred.
G. DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES			
<i>Wigs for hair loss resulting from alopecia areata are subject to \$350 maximum payment per plan year. No more than a 93-day supply of diabetic supplies are covered and dispensed at a time. Diabetic supplies purchased at a network pharmacy are not subject to the deductible.</i>			
Special dietary treatment for Phenylketonuria (PKU)	80% of the charges incurred. Deductible does not apply.	80% of the charges incurred. Deductible does not apply.	60% of the charges incurred.
Oral amino acid based elemental formula if it meets our medical coverage criteria	80% of the charges incurred.	80% of the charges incurred.	60% of the charges incurred.

COVERED SERVICES	<u>HealthPartners Benefits</u>	<u>APN Benefits</u>	<u>Non-Network Benefits</u>
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H. EMERGENCY AND URGENTLY NEEDED CARE SERVICES

Emergency and Urgently Needed Care Within the Network

Emergency and Urgently Needed care at network clinics	100% of the charges incurred, subject to a member copayment of \$15 per office visit. Deductible does not apply.	100% of the charges incurred, subject to a member copayment of \$15 per office visit. Deductible does not apply.	No Coverage.
Emergency care in a hospital emergency room, including professional services of a physician	80% of the charges incurred.	80% of the charges incurred.	No Coverage.

Emergency and Urgently Needed Care Outside the Network

Professional services of a physician, urgent care treatment, emergency room treatment and inpatient hospital services	80% of the charges incurred.	See HealthPartners Benefits.	See HealthPartners Benefits.
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I. HEALTH EDUCATION

Provider office visit/session in connection with preventive services	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	No Coverage.
Provider office visit/session in connection with the management of a chronic health problem (such as diabetes)	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	No Coverage.

J. HOME HEALTH SERVICES

Physical therapy, occupational therapy, speech therapy, respiratory therapy, home health aide services and palliative care	100% of the charges incurred, subject to a member copayment of \$15 per visit. Deductible does not apply.	100% of the charges incurred, subject to a member copayment of \$15 per visit. Deductible does not apply.	60% of the charges incurred.
	<i>If more than one home health visit occurs in a day, a separate copayment applies to each. For example, if a nurse and a physical therapist visit a member in the same day, a separate copayment will be charged for each visit.</i>		
TPN/IV therapy, skilled nursing services, non-routine prenatal/postnatal services, and phototherapy	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	60% of the charges incurred.

COVERED SERVICES	<u>HealthPartners Benefits</u>	<u>APN Benefits</u>	<u>Non-Network Benefits</u>
Routine prenatal/postnatal services and child health supervision services	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	60% of the charges incurred.
Maximum visits	If you are eligible to receive palliative care in the home and you are not homebound, there is a maximum of 8 visits per plan year. For all other services that meet the home health services requirements described in the member contract, there is a maximum of 120 visits per plan year.	If you are eligible to receive palliative care in the home and you are not homebound, there is a maximum of 8 visits per plan year. For all other services that meet the home health services requirements described in the member contract, there is a maximum of 120 visits per plan year.	If you are eligible to receive palliative care in the home and you are not homebound, there is a maximum of 8 visits per plan year. For all other services that meet the home health services requirements described in the member contract, there is a maximum of 60 visits per plan year.
<i>Each visit provided under the HealthPartners Benefits, APN Benefits and Non-Network Benefits counts toward the maximums shown above.</i>			

K. HOME HOSPICE SERVICES	80% of the charges incurred.	80% of the charges incurred.	No Coverage.
<i>Respite care is limited to 5 days per episode, and respite care and continuous care combined are limited to 30 days.</i>			

L. HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Medical or Surgical Hospital Services

a. Inpatient Hospital Services	80% of the charges incurred. Limited to 365 day maximum per period of confinement, subject to the combined day limit.	80% of the charges incurred. Limited to 365 day maximum per period of confinement, subject to the combined day limit.	60% of the charges incurred. Limited to 365 day maximum per period of confinement, subject to the combined day limit.
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Each member's admission or confinement, including that of a newborn child, is separate and distinct from the admission or confinement of any other member.

b. Outpatient Hospital, Ambulatory Care or Surgical Facility Services (to see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see benefits under Diagnostic Imaging Services, Laboratory Services and Physical Therapy)	80% of the charges incurred.	80% of the charges incurred.	60% of the charges incurred.
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COVERED SERVICES	<u>HealthPartners Benefits</u>	<u>APN Benefits</u>	<u>Non-Network Benefits</u>
Skilled Nursing Facility Care	See HealthPartners Network Inpatient Hospital Services Benefit. Limited to 120 day maximum per period of confinement, subject to the combined day limit.	See APN Network Inpatient Hospital Services Benefit. Limited to 120 day maximum per period of confinement, subject to the combined day limit.	See Non-Network Inpatient Hospital Services Benefit. Limited to 120 day maximum per period of confinement, subject to the combined day limit.
<i>Each day of services provided under the HealthPartners Benefits, APN Benefits and Non-Network Benefits combined, counts toward the maximums shown above.</i>			
M. INFERTILITY SERVICES	80% of the charges incurred. Deductible does not apply.	80% of the charges incurred. Deductible does not apply.	60% of the charges incurred.
Maximum Benefit:	\$5,000 per plan year.	\$5,000 per plan year.	\$5,000 per plan year.
<i>The maximum benefit is combined for the HealthPartners Benefits, APN Benefits and Non-Network Benefits. Drugs for the treatment of infertility are not subject to this maximum.</i>			
N. LABORATORY SERVICES			
<i>We cover services provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)</i>			
associated with covered preventive services	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	60% of the charges incurred.
for illness or injury	100% of the charges incurred.	100% of the charges incurred.	60% of the charges incurred.
O. MASTECTOMY RECONSTRUCTION BENEFIT	Coverage level is same as corresponding HealthPartners benefit, depending on type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding APN benefit, depending on type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Non-Network benefit, depending on type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.

COVERED SERVICES	<u>HealthPartners Benefits</u>	<u>APN Benefits</u>	<u>Non-Network Benefits</u>
P. OFFICE VISITS FOR ILLNESS OR INJURY			
Office Visits	100% of the charges incurred, subject to a member copayment of \$15 per office visit. Deductible does not apply.	100% of the charges incurred, subject to a member copayment of \$15 per office visit. Deductible does not apply.	60% of the charges incurred.
Convenience clinics	100% of the charges incurred, subject to a member copayment of \$10 per office visit. Deductible does not apply.	100% of the charges incurred, subject to a member copayment of \$10 per office visit. Deductible does not apply.	60% of the charges incurred.
Scheduled telephone visits	100% of the charges incurred, subject to a member copayment of \$10 per office visit. Deductible does not apply.	100% of the charges incurred, subject to a member copayment of \$10 per office visit. Deductible does not apply.	60% of the charges incurred.
E-visits	100% of the charges incurred, subject to a member copayment of \$10 per office visit. Deductible does not apply.	100% of the charges incurred, subject to a member copayment of \$10 per office visit. Deductible does not apply.	60% of the charges incurred.
Injections administered in a physician's office, other than immunizations			
Allergy injections	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	60% of the charges incurred.
All other injections	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	60% of the charges incurred.
Injectable and implantable birth control drugs/devices (this provision applies whether the birth control drug/device is used for birth control or for a medically necessary purpose other than birth control)	80% of the charges incurred. Deductible does not apply.	80% of the charges incurred. Deductible does not apply.	60% of the charges incurred.

COVERED SERVICES**HealthPartners Benefits****APN Benefits****Non-Network Benefits****Q. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY**

We cover services provided in a clinic. We also cover physical therapy provided in an outpatient hospital facility. (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)

Rehabilitative Care

100% of the charges incurred, subject to a member copayment of \$15 per visit. Deductible does not apply.

100% of the charges incurred, subject to a member copayment of \$15 per visit. Deductible does not apply.

60% of the charges incurred.

Physical and Occupational Therapy combined are limited to 20 visits per plan year.

Speech Therapy is limited to 20 visits per plan year.

Habilitative Care

100% of the charges incurred, subject to a member copayment of \$15 per visit. Deductible does not apply.

100% of the charges incurred, subject to a member copayment of \$15 per visit. Deductible does not apply.

No Coverage.

R. PRESCRIPTION DRUG SERVICES

Drugs and medications must be obtained at a Network Pharmacy.

Drugs and medications must be obtained at a Network Pharmacy.

Outpatient Drugs

100% of the charges incurred, subject to a member copayment of \$10 for generic preferred drugs and \$25 for brand name preferred drugs. Non-preferred drugs are covered at 100% of the charges incurred, subject to a member copayment of \$50.

Deductible does not apply.

Drugs for the treatment of sexual dysfunction are limited to six doses per month.

100% of the charges incurred, subject to a member copayment of \$10 for generic preferred drugs and \$25 for brand name preferred drugs. Non-preferred drugs are covered at 100% of the charges incurred, subject to a member copayment of \$50.

Deductible does not apply.

Drugs for the treatment of sexual dysfunction are limited to six doses per month.

60% of the charges incurred.

Drugs for the treatment of sexual dysfunction are not covered.

COVERED SERVICES**HealthPartners Benefits****APN Benefits****Non-Network Benefits**

Specialty Drugs which are self-administered

See Specialty Drugs benefit under HealthPartners benefits below.

Specialty Drugs are limited to drugs on the specialty drug list, and must be obtained from a designated vendor.

See Specialty Drugs benefit under APN benefits below.

Specialty Drugs are limited to drugs on the specialty drug list, and must be obtained from a designated vendor.

See Specialty Drugs benefit under Non-Network benefits below.

Tobacco cessation products, as determined by HealthPartners.

See HealthPartners Outpatient Drugs benefit.

See APN Outpatient Drugs benefit.

No Coverage.

Must be prescribed by a licensed provider and filled at a network pharmacy. Limited to a 180-day supply per plan year. No more than a 31-day supply will be covered and dispensed at a time.

Mail order drugs

You may also get outpatient prescription drugs which can be self administered through HealthPartners mail order service. Outpatient drugs ordered through this service are covered at the benefit percent shown in Outpatient Drugs above, subject to two copayments for each 93-day supply, or portion thereof.

Drugs for the treatment of sexual dysfunction are limited to 18 doses per 93-day supply.

For your convenience, you may also order insulin and tobacco cessation products through the mail order service without a discounted benefit.

Specialty Drugs are not available through the mail order service.

For information on how to obtain drugs through HealthPartners mail order service, refer to your enrollment material.

See HealthPartners Mail Order Drugs Benefit.

See HealthPartners Mail Order Drugs benefit.

COVERED SERVICES	<u>HealthPartners Benefits</u>	<u>APN Benefits</u>	<u>Non-Network Benefits</u>
Drugs for treatment of infertility	80% of the charges incurred. Deductible does not apply.	80% of the charges incurred. Deductible does not apply.	60% of the charges incurred.
Maximum Benefit:	\$3,000 per plan year.	\$3,000 per plan year.	None.
The maximum benefit is combined for the HealthPartners Benefits and APN Benefits.			
<i>Drugs for the treatment of infertility are limited to the products listed on the Infertility Products list, even if you have a non-preferred benefit for outpatient drugs.</i>			
Specialty Drugs which are self-administered	80% of the charges incurred, up to a maximum copayment of \$200. Deductible does not apply.	80% of the charges incurred, up to a maximum copayment of \$200. Deductible does not apply.	See Non-Network Outpatient Drugs benefit.
Drugs for the treatment of growth deficiency	80% of the charges incurred. Deductible does not apply.	80% of the charges incurred. Deductible does not apply.	60% of the charges incurred.
	<i>Specialty Drugs are limited to drugs on the specialty drug list, and must be obtained from a designated vendor.</i>	<i>Specialty Drugs are limited to drugs on the specialty drug list, and must be obtained from a designated vendor.</i>	
Contraceptive barrier devices	80% of the charges incurred. Deductible does not apply if purchased at a network pharmacy.	80% of the charges incurred. Deductible does not apply if purchased at a network pharmacy.	60% of the charges incurred.
<i>Unless otherwise specified in the Prescription Drug Services section, you may receive up to a 31-day supply per prescription. All drugs are subject to our utilization review process and quantity limits. In addition, certain drugs may be subject to any quantity limits applied as part of our trial program for new prescriptions. The trial drug program applies to new prescriptions for certain drugs which have high toxicity, low tolerance, high costs and/or high potential for waste. Trial drugs are indicated on the preferred drug list and/or the specialty drug list. Your first fill of a trial drug may be limited to less than a month supply. If the drug is well tolerated and effective, you will receive the remainder of your first month supply. If a flat dollar copay applies to the drug, you will pay no more than one copay each 31-day supply. A 93-day supply will be covered and dispensed at a time only at pharmacies that participate in our extended day supply program. No more than a 31-day supply of Specialty Drugs will be covered and dispensed at a time. We have written guidelines and procedures for granting an exception to the preferred drug list that are available to you upon request.</i>			
<i>If there is a generic equivalent, brand name drugs are only covered up to the charge that would apply to the generic drug, minus any required copayment. The brand name drug will not be covered as a non-preferred drug unless a physician requests that the drug be dispensed as written and we approve the request.</i>			
<i>The member copayment for a drug will not exceed the cost of the drug. If a member copayment is required, you must pay one member copayment for each 31-day supply, or portion thereof, except as follows:</i>			
<i>For Mail Order Drugs, see benefit above.</i>			

COVERED SERVICES	<u>HealthPartners Benefits</u>	<u>APN Benefits</u>	<u>Non-Network Benefits</u>
S. PREVENTIVE SERVICES			
1. Routine health exams and periodic health assessments	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	60% of the charges incurred.
2. Child health supervision services	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	60% of the charges incurred.
3. Routine prenatal services	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	60% of the charges incurred.
4. Routine postnatal services	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	60% of the charges incurred.
5. Routine screening procedures for cancer	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	60% of the charges incurred.
6. Routine eye and hearing exams	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	60% of the charges incurred.
7. Professional voluntary family planning services	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	60% of the charges incurred.
8. Adult immunization	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.	60% of the charges incurred.
T. SPECIFIED NON-NETWORK SERVICES	Coverage level is same as corresponding HealthPartners benefit, depending on type of service provided, such as Office Visits for Illness or Injury. See “Specified Non-Network Services” in section III. “Description of Covered Services” of the Group Membership Contract for a description of covered services.	Coverage level is same as corresponding APN benefit, depending on type of service provided, such as Office Visits for Illness or Injury. See “Specified Non-Network Services” in section III. “Description of Covered Services” of the Group Membership Contract for a description of covered services.	See HealthPartners Benefits for the services covered.
U. TRANSPLANT SERVICES	See HealthPartners Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.	See APN Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.	See Non-Network Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.