MedicareRx Prescription Drug Coverage

HealthPartners®

HealthPartners® Retiree National Choice (RNC)

2020 Summary of Benefits

Jan. 1, 2020 – Dec. 31, 2020
Saint Olaf (Emeriti) #19946

The RNC medical plan is paired with HealthPartners RNC Prescription Drug Plan (PDP) which provides coverage for your prescription medicines. These are separate plans so you'll have separate plan materials and member ID cards, but they work together to cover your health care needs.

You'll receive two member ID cards after you enroll. One is for your medical plan and the other is for your prescription drug plan. You'll also get a Group Certificate and an Evidence of Coverage (EOC). The Group Certificate explains exact coverage terms and conditions for the medical plan. The EOC explains exact coverage terms and conditions for your prescription drug plan.

We're here to help
Call us at **952-883-7428** or **866-993-7428**.
(TTY **711**)

Monday-Saturday, 8 a.m. to 6 p.m. CT (Oct. 1 – Dec. 7)
Monday-Friday, 8 a.m. to 6 p.m. CT (Dec. 8 – Sept. 30)

The service area for RNC includes all 50 states and territories.

#19946 RNC St. Olaf SB (9/19) ©2019 HealthPartners
S1822_118610_M IR 09/30/2019
This document is available in other formats such as Braille, large print or audio. HealthPartners is a PDP plan with a Medicare contract. Enrollment in HealthPartners depends on contract renewal.

MEDICAL BENEFITS

BENEFITS	WHAT YOU PAY		
	PLAN 1	PLAN 2	PLAN 3
Monthly Premium: Contact your employer for premium information. If you're billed directly by HealthPartners, call us at the numbers on the front page for your premium information.			
Deductible	You have a $100 annual deductible for outpatient services for illness or injury. Part B drugs, durable medical equipment and diabetes supplies filled through the pharmacy network are excluded.	You have a $150 annual deductible for outpatient services for illness or injury. Part B drugs, durable medical equipment and diabetes supplies filled through the pharmacy network are excluded.	You have a $200 annual deductible for outpatient services for illness or injury. Part B drugs, durable medical equipment and diabetes supplies filled through the pharmacy network are excluded.
Maximum out-of-pocket responsibility *(The most you'll pay out-of-pocket for the year; does not include prescription drugs. Not all services apply to the maximum out-of-pocket responsibility. Please see the plan's EOC for details.)*	$1,750 (Medical)	$3,000 (Medical)	$5,000 (Medical)
Inpatient hospital coverage	$100 per benefit period	$200 per benefit period	$500 per benefit period
Outpatient hospital services	$0	$0	$0
Outpatient surgery	$0	$0	$0
Ambulatory surgery center (ASC)	$0	$0	$0
Doctor visits	Primary: $15 Specialty: $30	Primary: $20 Specialty: $40	Primary: $25 Specialty: $45
Preventive care	$0	$0	$0
Emergency care *(If you're admitted to the hospital for the same condition within 24 hours, you don't pay your share of the cost for emergency care.)*	$50	$50	$100
Urgently needed services	$30	$40	$50
Diagnostic services/Labs/Imaging *(Cost for these services may vary based on place of service.)*	Diagnostic radiology (i.e. MRI, CT scans): $0 Labs: $0 Diagnostic tests and procedures: $0 Outpatient X-rays: $0	Diagnostic radiology (i.e. MRI, CT scans): $0 Labs: $0 Diagnostic tests and procedures: $0 Outpatient X-rays: $0	Diagnostic radiology (i.e. MRI, CT scans): 20% Labs: 20% Diagnostic tests and procedures: 20% Outpatient X-rays: 20%

BENEFITS	WHAT YOU PAY		
	PLAN 1	PLAN 2	PLAN 3
Hearing services	Routine exam: $0 Hearing aids: $1,000 credit every two years	Routine exam: $0 Hearing aids: $1,000 credit every two years	Routine exam: $0 Hearing aids: $1,000 credit every two years
Dental services	Medicare-covered dental: $0	Medicare-covered dental: $0	Medicare-covered dental: $0
Vision services	Up to one routine eye exam per year: $0 Glasses or contact lenses after cataract surgery: $0	Up to one routine eye exam per year: $0 Glasses or contact lenses after cataract surgery: $0	Up to one routine eye exam per year: $0 Glasses or contact lenses after cataract surgery: $0
Mental health services (*Including inpatient)*	Inpatient visit: $100 per benefit period Outpatient group therapy visit: $15 Outpatient individual therapy visit: $15	Inpatient visit: $200 per benefit period Outpatient group therapy visit: $20 Outpatient individual therapy visit: $20	Inpatient visit: $500 per benefit period Outpatient group therapy visit: $25 Outpatient individual therapy visit: $25
Skilled nursing facility	$0 *(We cover up to 100 days.)*	$0 *(We cover up to 100 days.)*	$0 *(We cover up to 100 days.)*
Rehabilitation services	Occupational therapy visit: $0 Physical therapy visit: $0 Speech and language therapy visit: $30	Occupational therapy visit: $15 Physical therapy visit: $15 Speech and language therapy visit: $40	Occupational therapy visit: $50 Physical therapy visit: $50 Speech and language therapy visit: $50
Ambulance transportation in the US	$0	10%	20%
Transportation	Not covered	Not covered	Not covered
Medicare Part B drugs *(Prior authorization may be required.)*	20% of the cost for chemotherapy drugs and other Part B drugs		

The summary of benefits above is for your medical plan. This information is not a complete description of benefits. Call 952-883-7428 or 866-993-7428; TTY: 711 for more information. Your HealthPartners® Retiree National Choice Prescription Drug Plan (PDP) benefits are outlined on the next page. If you have questions about your HealthPartners RNC summary of benefits, give us a call at the numbers on the front page.

This plan may not cover all of your health care expenses. It's important to read your Group Certificate closely to see which expenses are covered.

PRESCRIPTION DRUG BENEFITS

Costs may change depending on the pharmacy you choose and when you enter another Part D phase. Call us or check the Evidence of Coverage online when you log into your *my*HealthPartners account at **healthpartners.com** for more information. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.

<table>
<tr><td>Prescription Drug Formulary</td><td colspan="3">Your prescription drug formulary is Medicare Formulary II.</td></tr>
<tr><td>Phase 1: Deductible
(If you have one)</td><td colspan="3">You have an annual $150 deductible for Tier 3 (Preferred-Brand), Tier 4 (Non-Preferred Brand Drug) and Tier 5 (Specialty) Part D prescription drugs.</td></tr>
<tr><td rowspan="3">Phase 2: Initial Coverage
(After you reach your deductible, if you have one)

Tier 1: Preferred Generic
Tier 2: Generic
Tier 3: Preferred Brand
Tier 4: Non-preferred Brand Drug
Tier 5: Specialty</td><td colspan="3">What you pay at standard retail and standard mail order pharmacies:</td></tr>
<tr><td><u>Plan 1:</u>
One-month supply
Tier 1: $10
Tier 2: $10
Tier 3: $20
Tier 4: $40
Tier 5: 25%</td><td><u>Plan 2:</u>
One-month supply
Tier 1: $10
Tier 2: $15
Tier 3: $45
Tier 4: $65
Tier 5: 25%</td><td><u>Plan 3:</u>
One-month supply
Tier 1: $15
Tier 2: $20
Tier 3: $50
Tier 4: $90
Tier 5: 34%</td></tr>
<tr><td>Three-month supply
Tier 1: $30
Tier 2: $30
Tier 3: $60
Tier 4: $120
Tier 5: Not offered</td><td>Three-month supply
Tier 1: $30
Tier 2: $45
Tier 3: $135
Tier 4: $195
Tier 5: Not offered</td><td>Three-month supply
Tier 1: $45
Tier 2: $60
Tier 3: $150
Tier 4: $270
Tier 5: Not offered</td></tr>
<tr><td colspan="3">At preferred mail order pharmacies, you get a three-month supply for the price of two months. You pay the same amount listed above for a one-month supply.</td></tr>
<tr><td>Phase 3: Coverage Gap
(“Donut Hole”)</td><td colspan="3">Plan 1: The same cost-sharing applies to each tier in the Coverage Gap Stage as in the Initial Coverage Stage.
Plan 2 and Plan 3: You pay 25% for generic drugs and 25% for brand name drugs.</td></tr>
<tr><td>Phase 4: Catastrophic Coverage</td><td colspan="3">Plan 1: You pay $3.60 or 5%, whichever is greater, for generic drugs. You pay $8.95 or 5%, whichever is greater, for brand name drugs. (Not to exceed the copays in the Initial Coverage stage.)
Plan 2 and Plan 3: You pay $3.60 or 5%, whichever is greater, for generic drugs. You pay $8.95 or 5%, whichever is greater, for brand name drugs.</td></tr>
</table>

This information is not a complete description of benefits. Call 952-883-7428 or 866-993-7428; TTY: 711 for more information.

ADDITIONAL BENEFITS

BENEFITS	WHAT YOU PAY		
Chiropractic care	$30	$40	$45
Acupuncture	$30	$40	$45
Routine physical exams	$0	$0	$0
Medical equipment/supplies *(Things like wheelchairs, oxygen, braces, artificial limbs, etc.)*	Durable medical equipment: 10% Prosthetics: 10% Diabetes supplies: 10%	Durable medical equipment: 10% Prosthetics: 10% Diabetes supplies: 10%	Durable medical equipment: 20% Prosthetics: 20% Diabetes supplies: 20%
Wellness program	The Silver&Fit® Exercise & Healthy Aging Program: $0 – Get a membership at a large network of fitness facilities. Or, a home fitness kit for members who prefer to work out at home.		

ADDITIONAL MEDICAL PLAN INFORMATION

MAKE SURE YOUR PHARMACIES ARE COVERED

You can access your 2020 plan materials by logging in on your *my*healthpartners account at **healthpartners.com.** If you're signed up for paperless delivery we'll send you an email when your plan materials are available for viewing.

PROVIDER PAYMENT

Because you're a Medicare beneficiary, your providers will bill Medicare first when you get services.
For covered services from providers that are Medicare certified and accept Medicare assignment, provider payment is:

1. The Medicare allowable amount of the provider's billed charges for a given medical/surgical service, procedure or item.
2. Or, the usual and customary charge if Medicare has not established a fee for a particular service.

For covered services from providers that are Medicare certified but do not accept Medicare assignment, provider payment is:

1. The Medicare limiting amount of the provider's billed charges for a given medical/surgical service, procedure or item.
2. Or, the usual and customary charge if Medicare has not established a fee for a particular service.

For covered services from providers that are not Medicare certified, payment is the provider's charge for a given medical/surgical service procedure or item, according to the Usual and Customary Charge.

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

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 this plan's effective date, and on or before this plan's termination date.

HealthPartners negotiates with some providers to pay discounted rates. In those cases, coinsurance (a specific percentage of the charge) is based on that discounted amount. Copays (flat amounts specified in advance for categories of service, such as office visits or prescriptions) are based on an aggregate of billed charges for that type of service.