hpi | Health Plans, Inc.

Summary of Benefits

Operating Engineers – Allina

*Medical Benefits for Group **AC3** Effective 01/1/2023*

	NETWORK	***NON-NETWORK***
Annual Deductible		
Single:	$250	$500
Family:	$500	$1,000
Annual Out-Of-Pocket Maximum		
Single:	$2,500	$2,500
Family*:	$5,000	$5,000
Preventive Care		
Routine Physicals	100%	80% after deductible
Well Child Care	100%	80% after deductible
Routine Mammography	100%	80% after deductible
Routine GYN Exam	100%	80% after deductible
Doctor's Services		
Office Visits – including all charges billed with visit	$15 copay then 100%	80% R&C* after deductible
Chiropractic Care (maximum of 10 visits per person per calendar year)	$15 copay then 100%	$15 copay then 100%
Speech, Physical & Occupational Therapy	$15 copay then 100%	80% R&C* after deductible
Chemotherapy & Radiation Therapy	100% after deductible	80% R&C* after deductible
Maternity	100% after deductible	80% R&C* after deductible
Anesthesia	100% after deductible	80% R&C* after deductible
Hospital Services		
Inpatient**	100% after deductible	80% R&C* after deductible
Outpatient	100% after deductible	80% R&C* after deductible
Emergency Room (copay waived if admitted)	$100 copay then 100%	$100 copay then 100%
Mental Health/Substance Abuse		
Mental Health		
Inpatient+	100% after deductible	80% R&C* after deductible
Outpatient (MAP precert not required)	100% deductible waived	80% R&C* after deductible (paid in network with MAP approval)
Other Services		
Skilled Nursing Facility Care/Extended Care Facility (90 days)	100% after deductible	80% R&C* after deductible
Home Health Care (100 visit or 200 hours per calendar year)	100% after deductible	80% R&C* after deductible
Hospice Care	100% deductible waived	80% R&C* after deductible
Prosthetics	100% after deductible	80% R&C* after deductible
Treatment for Temporomandibular Joint Dysfunction ($1,000 per person per calendar year)	100% deductible waived	80% R&C* after deductible
Ambulance	100% after deductible	100% after In-Network deductible
Durable Medical Equipment	100% after deductible	80% R&C* after deductible
Diagnostic Lab, X-Ray & Clinical Tests	100% after deductible	80% R&C* after deductible
Allergy Injections	100% after deductible	80% R&C* after deductible
Infertility Testing	100% after deductible	80% R&C* after deductible
Infertility Treatment	not covered	not covered

+PRECERTIFICATION MUST BE WITH MODERN ASSISTANCE PROGRAMS. FAILURE TO PRECERTIFY WILL RESULT IN PENALTY OF 20% FOR ALL SERVICES

Optum Rx Discount Prescription Drug Benefit	
Retail Pharmacy (*up to a 34-day supply)*	$15 Generic / $30 Brand / $60 Non Preferred Brand / $60 Specialty
Mail Order *(up to a 34-90-day supply)*	$30 Generic / $60 Brand / $90 Non Preferred Brand / $90 Specialty
RX Out-Of-Pocket Maximum	Single: $3,500 / Family: $7,000

Charges for birth control medication and pre-natal vitamins are covered under the prescription plan. Smoking Cessation Medications (prescription only) are covered under the prescription plan.

**The plan participant is also responsible to pay any amount above the reasonable and customary allowance when services are rendered by an out-of-network provider.*

*****UTILIZATION REVIEW / HOSPITAL PRE-CERTIFICATION/COMPLEX CASE MANAGEMENT*** is provided by Care Management Services (CMS). The CMS toll-free number is located on your ID card. If you fail to follow the pre-admission certification requirements, your benefits will be reduced by 20% on otherwise covered charges of a hospital or other facility for each admission.

NOTES: This Summary provides you with an overview of your Plan benefits and is not a complete statement of all Plan provisions, limitations, and exclusions. Please refer to your Plan Document and amendments for complete details. In the event of any inconsistency between this Summary and your Plan Document, the Plan Document and any applicable amendments will govern.