HealthPartners

**2020-2021 Fridley ISD #14**
**Group #3138**

The following provides an overview of your HealthPartners coverage.
For exact coverage details consult a Group Membership Contract or Summary Plan Description or call Member Services at 952-883-5000 or 1-800-883-2177

| Medical Plan Highlights | HP Classic Choice Plan ME 100 | | HP Primary Choice Plan HP 60 | | NationalONE Plan Nat 1 | | |
|---|---|---|---|---|---|---|---|
| Partial listing of covered services | In Network | Out of Network | In Network | Out of Network | In Network | Out of Network | |
| **Deductible and Out-of-Pocket** | | | | | | | |
| Lifetime Maximum | Unlimited | $1 Million | Unlimited | $1 Million | Unlimited | $2 Million | |
| Plan year deductible (non-embedded) | None | $300 single<br>$900 family | None | $300 single<br>$900 family | $1,000 single<br>$1,500 single +1<br>$2,000 family | $2,000 single<br>$2,500 single +1<br>$3,000 family | |
| Plan year **medical** out-of-pocket maximum | $1,000 single<br>$2,000 family | $4,000 single<br>$6,000 family | $1,000 single<br>$2,000 family | $4,000 single<br>$6,000 family | $2,000 single<br>$2,500 single +1<br>$3,000 family | $5,000 single<br>$6,000 single +1<br>$7,000 family | |
| **Preventive Healthcare** | | | | | | | |
| Routine physical & eye exams, well-child care | 100% Coverage | You pay 100% | 100% Coverage | You pay 100% | 100% coverage | 35% after Deductible | |
| Prenatal & postnatal care | | 25% after Deductible | | 25% after Deductible | | | |
| Immunizations | | You pay 100% | | You pay 100% | | | |
| **Office Visits** | | | | | | | |
| Illness or injury | $20 Copay | 25% after Deductible | $20 Copay | 25% after Deductible | 20% after Deductible | 35% after Deductible | |
| Physical, occupational and speech therapy | | | | | | | |
| Chiropractic care | | | | | | | |
| Mental / Chemical health care | | | | | | | |
| Allergy Injections | 100% Coverage | | 100% Coverage | | You pay nothing after Deductible | | |
| **Convenience Care** | | | | | | | |
| Convenience clinics (retail clinics), eVisits | $10 Copay | 25% after Deductible | $10 Copay | 25% after Deductible | 20% after Deductible | 35% after Deductible | |
| Online Care - Virtuwell | First three visits free, then same as Convenience Care benefit | You pay 100% | First three visits free, then same as Convenience Care benefit | You pay 100% | First three visits free, then same as Convenience Care benefit | You pay 100% | |
| **Emergency Care** | | | | | | | |
| Care at an urgent care clinic or medical center | $20 Copay | HealthPartners in-network Emergency Care benefit | $20 Copay | HealthPartners in-network Emergency Care benefit | 20% after Deductible | 35% after Deductible | |
| Emergency care at a hospital ER & Ambulance | $75 Copay | | $75 Copay | | | HealthPartners in-network benefit | |
| Ambulance | You pay 20% | | You pay 20% | | | | |
| **Inpatient Hospital Care** | | | | | | | |
| Illness or injury, mental/chemical health | $100 per admission | 25% after Deductible | $100 per admission | 25% after Deductible | 20% after Deductible | 35% after Deductible | |
| **Outpatient Care** | | | | | | | |
| Scheduled outpatient procedures | $100 per admission | 25% after Deductible | $100 per admission | 25% after Deductible | 20% after Deductible | 35% after Deductible | |
| Outpatient MRI and CT Scan | You pay 20% | 25% after Deductible | You pay 20% | 25% after Deductible | | | |
| **Durable Medical Equipment (DME)** | | | | | | | |
| DME & prosthetic devices | You pay 20% | 25% after Deductible | You pay 20% | 25% after Deductible | 20% after Deductible | 35% after Deductible | |
| **Pharmacy Highlights** | | | | | | | |
| Partial listing of covered services | | | | | | | |
| **Preferred Rx Formulary** | **Retail Pharmacy (up to a 30-day supply or one cycle of oral contraceptives)** | | **Retail Pharmacy (up to a 30-day supply or one cycle of oral contraceptives)** | | **Retail Pharmacy (up to a 30-day supply or one cycle of oral contraceptives)** | | |
| Rx Specialty Drugs | 80% coverage up to $200 | 25% after Deductible | 80% coverage up to $200 | 25% after Deductible | 80% coverage up to $200 | 35% after Deductible | |
| Generic preferred | You pay $10 | | You pay $10 | | You pay $10 | | |
| Brand preferred | You pay $20 | | You pay $20 | | You pay $20 | | |
| | **HealthPartners Mail Order Pharmacy (up to a 90-day supply)** | | **HealthPartners Mail Order Pharmacy (up to a 90-day supply)** | | **HealthPartners Mail Order Pharmacy (up to a 90-day supply)** | | |
| Generic preferred | You pay $20 | No coverage | You pay $20 | No coverage | You pay $20 | No coverage | |
| Brand preferred | You pay $40 | | You pay $40 | | You pay $40 | | |
| **Cost** | | | | | | | |
| **(Monthly Premium)** | **Full Premium** | **Employee Cost** | **Full Premium** | **Employee Cost** | **Full Premium** | **Employee Cost** | **VEBA Contribution (District Funded)** |
| **Single** | **$807.12-$807.12** | **$0.00** | **$849.62 – $807.12** | **$42.50** | **$704.99 - $704.99** | **$0.00** | **$102.13** |
| **Employee + 1** | **$1,444.86 -$1,170.34** | **$274.52** | **$1,502.96 - $1,170.34** | **$350.62** | **$1,262.06 - $1,096.41** | **$165.65** | **$73.93** |
| **Family** | **$2,074.62 - $1,535.22** | **$539.40** | **$2,183.79 - $1,535.22** | **$648.57** | **$1,812.10 - $1,440.19** | **$371.91** | **$95.03** |

Premiums based on full time FTE for employment classes; prorated amounts for less than full time FTE