2021-2022 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	Classic Plan $20 Copay Plan		National One High Deductible Plan		
	The network for both plans is the HP Open Access Network.				
Partial listing of covered services	In Network	Out of Network	In Network	Out of Network	
Deductible and Out-of-Pocket					
Lifetime Maximum	Unlimited	$1 Million	Unlimited	$2 Million	
Plan year deductible (non-embedded)	None	$300 single $900 family	$1,000 single $1,500 single +1 $2,000 family	$2,000 single $2,500 single +1 $3,000 family	
Plan year **medical** out-of-pocket maximum	$1,000 single $2,000 family	$4,000 single $6,000 family	$2,000 single $2,500 single +1 $3,000 family	$5,000 single $6,000 single +1 $7,000 family	
Preventive Healthcare					
Routine physical & eye exams, well-child care	100% Coverage	You pay 100%	100% coverage	35% after Deductible	
Prenatal & postnatal care		25% after Deductible			
Immunizations		You pay 100%			
Office Visits					
Illness or injury	$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		You pay nothing after Deductible		
Convenience Care					
Convenience clinics (retail clinics), eVisits	$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%	
Emergency Care					
Care at an urgent care clinic or medical center	$20 Copay	HealthPartners in-network Emergency Care benefit	20% after Deductible	35% after Deductible	
Emergency care at a hospital ER & Ambulance	$75 Copay			HealthPartners in-network benefit	
Ambulance	You pay 20%				
Inpatient Hospital Care					
Illness or injury, mental/chemical health	$100 per admission	25% after Deductible	20% after Deductible	35% after Deductible	
Outpatient Care					
Scheduled outpatient procedures	$100 per admission	25% after Deductible	20% after Deductible	35% after Deductible	
Outpatient MRI and CT Scan	You pay 20%	25% after Deductible			
Durable Medical Equipment (DME)					
DME & prosthetic devices	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)**		
Rx Specialty Drugs	80% coverage up to $200	25% after Deductible	80% coverage up to $200	35% after Deductible	
Generic preferred	You pay $10		You pay $10		
Brand preferred	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)**		
Generic preferred	You pay $20	No coverage	You pay $20	No coverage	
Brand preferred	You pay $40		You pay $40		
Cost					**VEBA Contribution**
(Monthly Premium)	**Full Premium**	**Employee Cost**	**Full Premium**	**Employee Cost**	**(District Funded)**
Single	**$807.12-$807.12**	**$0.00**	**$704.99 - $704.99**	**$0.00**	**$102.13**
Employee + 1	**$1,444.86 -$1,170.34**	**$274.52**	**$1,262.06 - $1,096.41**	**$165.65**	**$73.93**
Family	**$2,074.62 - $1,535.22**	**$539.40**	**$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