HealthPartners

2023-2024 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	**$823.26-823.26**	**$0.00**	**$719.09-719.09**	**$0.00**	**$104.17**
Employee + 1	**$1473.76-1193.75**	**$280.01**	**$1287.30-1118.34**	**$168.96**	**$75.41**
Family	**$2116.11-1565.92**	**$550.19**	**$1848.37-1468.99**	**$379.38**	**$96.93**

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