2019-2020 Fridley ISD
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. To find a doctor in your network search here https://www.healthpartners.com/hp/insurance/find-a-provider/group-medical/index.html or call member services.

Medical Plan Highlights	HP Classic Choice		HP *Primary Clinic* Plan		NationalONE Plan *Open*	
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
Calendar year deductible	None	$300/single $900family	None	$300/single $900/family	$1,000/single $1,500/single +1 $2,000/famiily	$2,000/single $2,500/single +1 $3,000/famiily
Calendar year **medical** out-of-pocket maximum	$1,000/single $2,000/family	$4,000/single $6,000/family	$1,000/single $2,000/family	$4,000/single $6,000/family	$2,000/single $2,500/single +1 $3,000/famiily	$5,000/single $6,000/single +1 $7,000 famiily
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%

2019-2020 Fridley ISD
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. To find a doctor in your network search here https://www.healthpartners.com/hp/insurance/find-a-provider/group-medical/index.html or call member services.

Medical Plan Highlights	HP Classic Choice		HP *Primary Clinic* Plan		NationalONE Plan *Open*		
Partial listing of covered services	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	
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		**Retail Pharmacy** (up to a 30-day supply		**Retail Pharmacy** (up to a 30-day		
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		**HealthPartners Mail Order**		**HealthPartners Mail Order**		
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							**VEBA Contribution**
(Monthly Premium)	**Full Premium**	**Employee Cost**	**Full Premium**	**Employee Cost**	**Full Premium**	**Employee Cost**	**(District Funded)**
Single	795.19-795.19	**$0.00**	837.06-795.19	**$41.87**	694.57-694.57	**$0.00**	$100.62
Employee +1	1423.51-1153.04	**$270.47**	1498.48-1153.04	**$345.44**	1243.41-1080.21	**$163.20**	$72.83
Family	2043.96-1512.53	**$531.43**	2151.52-1512.53	**$638.99**	1785.32-1418.91	**$366.41**	$93.62