HealthPartners

Inver Grove Heights Schools

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

Medical Plan Highlights	$30 Open Access Choice Copay	$500 Open Access Choice	$15 Select Choice Copay	$20 Select Choice Copay	$1,000 Choice Deductible
Partial listing of covered services	**In Network**	**In Network**	In Network	**In Network**	**In Network**
Deductible and Out-of-Pocket					
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Calendar Plan year deductible	None	None	None	None	$1,000 per person $2,000 per family
Calendar Plan year **medical** out-of-pocket maximum	$3,000 per person $5,000 per family	$3,000 per person $5,000 per family	$1,000 per person $5,000 per family	$1,500 per person $5,000 per family	$2,000 per person $4,000 per family
Preventive Healthcare					
Routine physical and eye examinations	100% Coverage	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Well Child to 6, child immunizations and Prenatal					
Postnatal, family planning & cancer screenings					
Office Visits					
Illness or injury	$30 copayment	$30 copayment	$15 copayment	$20 copayment	80% after deductible
Physical, occupational therapy, speech therapy					
Chiropractic care					
Mental / Chemical health care					
Virtwell	Three Free	Three Free	Three free	Three free	Three Free
Convenience Clinic / E-Visit	$15 Copayment	$15 Copayment	$5 Copayment	$10 Copayment	80% after deductible
Emergency Care					
Care at an urgent care clinic or medical center	$30 copayment	$30 copayment	$15 copayment	$20 copayment	80% after deductible
Emergency care at a hospital ER	$75 copayment	$75 copayment	$75 copayment	$75 copayment	
Ambulance	80% coverage	80% coverage	80% coverage	80% coverage	
Inpatient Hospital Care					
Illness or injury	100% coverage	$500 copayment	100% coverage	80% coverage	80% after deductible
Mental / Chemical health care					
Outpatient Care					
Scheduled outpatient procedures	100% coverage	$30 copayment	100% coverage	80% coverage	80% after deductible
Durable Medical Equipment (DME)					
DME & prosthetic devices	80% coverage	80% coverage	80% coverage	80% coverage	80% after deductible
Pharmacy Highlights Partial listing of covered services					
	Retail Pharmacy (up to a 31-day supply)	**Retail Pharmacy (up to a 31-day supply)**	**Retail Pharmacy (up to a 31-day supply)**	**Retail Pharmacy (up to a 31-day supply)**	**Retail Pharmacy (up to a 31-day supply)**
Generic preferred	$12 copayment	$12 copayment	$12 copayment	$12 copayment	$12 copayment
Brand preferred	$35 copayment	$35 copayment	$35 copayment	$35 copayment	$35 copayment
Medications not on the formulary	$50 copyament	$50 copyament	$50 copayment	$50 copyament	$50 copyament
	Order Pharmacy (up to	**Pharmacy (up to a 93-day**	**Pharmacy (up to a 93-day**	**Pharmacy (up to a 93-day**	**Pharmacy (up to a 93-day**
Generic preferred	$36 copayment	$36 copayment	$36 copayment	$36 copayment	$36 copayment
Brand preferred	$105 copayment	$105 copayment	$105 copayment	$105 copayment	$105 copayment
Medications not on the formulary	$150 copyament	$150 copyament	$150 copyament	$150 copyament	$150 copyament