

The following is an overview of your HealthPartners coverage. Where there is a flat dollar amount (\$) listed, this is a copayment. Where there is a percentage amount (%), this is coinsurance. For exact terms and conditions, consult your plan materials or call Member Services at 952-883-5000 or 800-883-2177.

Medical Plan Highlights Partial listing of covered services	Open Access Choice		Empower HSA		
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Co. HSA contribution with wellness program			\$700 individual/ \$1,400 family		
Co. HSA contribution without wellness program			\$450 individual/ \$900 family		
Lifetime Maximum	Unlimited	\$1,000,000	Unlimited	\$1,000,000	
Calendar year deductible with wellness program	\$250 individual \$500 family	\$1,000 individual \$2,000 family	\$2,400 individual \$4,200 family	\$4,800 individual \$8,400 family	
Calendar year deductible without wellness program	\$500 individual \$1,000 family	\$1,000 individual \$2,000 family	\$2,400 individual \$4,200 family	\$4,800 individual \$8,400 family	
Calendar year medical out-of-pocket maximum (including deductible)	\$3,500 individual \$7,000 family	\$7,000 individual \$14,000 family	\$3,500 individual \$7,000 family	\$7,000 individual \$14,000 family	
Preventive Health Care					
Routine physical and eye examinations	100% coverage, no deductible	No coverage	100% coverage, no deductible	No coverage	
Prenatal, postnatal care and well child care	100% coverage, no deductible	60% coverage after deductible	100% coverage, no deductible	No coverage	
Immunizations	100% coverage, no deductible	No coverage	100% coverage, no deductible	No coverage	
Office Visits					
Illness or injury	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible	
Mental/chemical health care	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible	
Physical, occupational and speech therapy	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible	
Chiropractic care (for neuromusculo-skeletal conditions only)	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible	
Allergy injections	100% coverage	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible	
Convenience Care					
Convenience clinics (retail clinics), eVisits	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible	
Online care (virtuwell)	80% coverage after deductible	No coverage	90% coverage after deductible	No coverage	
Emergency Care					
Urgently needed care at an urgent care clinic or medical center	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible	
Emergency care at a hospital ER	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible	
Ambulance	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible	
Inpatient Hospital Care					
Illness or injury	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible	
Mental/chemical health care	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible	
Outpatient Care					
Scheduled outpatient procedures	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible	
Outpatient MRI and CT scan	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible	
Durable Medical Equipment					
Durable Medical Equipment and prosthetic devices	80% coverage after deductible	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible	
Pharmacy Highlights		Open Access Choice		Empower HSA	
Partial listing of covered services	Participating Pharmacies	Non Participating Pharmacies	Participating Pharmacies	Non Participating Pharmacies	
Retail Pharmacy - (up to a 31-day supply or one cycle of oral contraceptives)					
Generic from the formulary	\$15 copay	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible	
Brand from the formulary	\$30 copay	60% coverage after deductible	90% coverage after deductible	60% coverage after deductible	
Specialty Rx purchased through Walgreens Specialty Pharmacy	80% coverage, max copayment is \$200 per prescription per month.	No coverage	90% coverage, max copayment is \$200 per prescription per month.	No coverage	
HealthPartners Mail Order Pharmacy - (up to a 93-day supply)					
Generic from the formulary	\$30 copay	No coverage	90% coverage after deductible	No coverage	
Brand from the formulary	\$60 copay	No coverage	90% coverage after deductible	No coverage	

Note: the family HSA plan includes an imbedded individual deductible.