# Medica

## Medical Rates for MAWSECO

Effective Date: 10/01/2023

| | Option 1 | Option 2 | Option 3 |
|---|---|---|---|
| **Plan Name** | **MSI Medica Choice Passport ASO 1000-25-20% Plan** | **MSI Medica Choice Passport ASO 3500-0% HSA** | **MSI Medica Choice Passport ASO 6750-0% HSA** |
| HSA | No | Yes | Yes |
| Lifetime Benefit Maximum | Unlimited | Unlimited | Unlimited |
| Calendar Year Deductible | $1,000 single / $2,000 family | $3,500 single / $7,000 family | $6,750 single / $13,500 family |
| Calendar Year Out-of-Pocket Maximum | $3,000 single / $6,000 family | $3,500 single / $7,000 family | $6,750 single / $13,500 family |
| Coinsurance | 20% | 0% | 0% |
| **Doctor's Office*** | | | |
| Primary Care Office Visit | $25 copay per visit | 0% after deductible | 0% after deductible |
| Specialist Office Visit | $25 copay per visit | 0% after deductible | 0% after deductible |
| Preventive Care (screening, immunization) | 0% | 0% | 0% |
| Diagnostic Test (x-ray, blood work) | 0% | 0% after deductible | 0% after deductible |
| Imaging (CT/PET scan, MRIs) | 20% after deductible | 0% after deductible | 0% after deductible |
| **Prescription Drugs*** | | | |
| Preventive—Generic Drugs | Not covered | 0% | 0% |
| Preventive—Preferred Brand Drugs | Not covered | 0% | 0% |
| Preventive—Non-Preferred Brand Drugs | Not covered | Not covered | Not covered |
| Retail—Generic Drugs (31-day supply) | $20 copay per prescription | 0% after deductible | 0% after deductible |
| Retail—Preferred Brand Drugs (31-day supply) | $50 copay per prescription | 0% after deductible | 0% after deductible |
| Retail—Non-Preferred Brand Drugs (31-day supply) | $100 copay per prescription | 0% after deductible | 0% after deductible |
| Specialty Drugs (31-day supply) | Preferred: $200 copay per prescription, then 20%; Non-Preferred: 40% | 0% after deductible | 0% after deductible |
| Mail Order—Generic Drugs (93-day supply) | $40 copay per prescription | 0% after deductible | 0% after deductible |
| Mail Order—Preferred Brand Drugs (93-day supply) | $100 copay per prescription | 0% after deductible | 0% after deductible |
| Mail Order—Non-Preferred Brand Drugs (93-day supply) | $200 copay per prescription | 0% after deductible | 0% after deductible |
| **Hospital Services*** | | | |
| Emergency Room | 20% after deductible | 0% after deductible | 0% after deductible |
| Inpatient | 20% after deductible | 0% after deductible | 0% after deductible |
| Outpatient Surgery | 20% after deductible | 0% after deductible | 0% after deductible |
| Ambulance Service | 20% after deductible | 0% after deductible | 0% after deductible |
| **Other Services*** | | | |
| Maternity Services | 0% | Prenatal care: 0%; Postnatal care: 0% after deductible | Prenatal care: 0%; Postnatal care: 0% after deductible |
| All other maternity hospital/physician services | 20% after deductible | 0% after deductible | 0% after deductible |
| Muscle Manipulation Services | $25 copay per visit | 0% after deductible | 0% after deductible |
| Physical, Occupational and Speech Therapy Services | $25 copay per visit | 0% after deductible | 0% after deductible |
| Skilled Nursing (120-day calendar year maximum) | 20% after deductible | 0% after deductible | 0% after deductible |
| ***For more detailed plan information and for out-of-network benefits, please see your summary of benefits and coverage** | | | |
| | **Rates (Billed)** | **Rates (Billed)** | **Rates (Billed)** |
| **Single Premium** | $778.36 | $679.98 | $566.66 |
| **Coop Contribution** | -$800.00 | -$800.00 | -$800.00 |
| **Emp Cost per month Single** | $0.00 | $0.00 | $0.00 |
| **Emp Cost per pay period Single** | **$0.00** | **$0.00** | **$0.00** |
| **Annual Amount into HSA/403b** | **N/A** | **$1,440.24** | **$2,800.08** |
| **Emp+Family Premium** | $1,943.72 | $1,698.04 | $1,415.04 |
| **Coop Contribution** | -$1,500.00 | -$1,500.00 | -$1,500.00 |
| **Emp Cost per month Family** | $443.72 | $198.04 | $0.00 |
| **Emp Cost per pay period Family** | **$221.86** | **$99.02** | **$0.00** |
| **Annual Amount into HSA/403b** | **N/A** | **$0.00** | **$1,019.52** |

Rates based on tentative agreement - not yet ratified.

# HealthPartners Dental

Effective Date: 7/01/2023

| **Plan highlights** | **In-network** | **Out-of-Network** |
|---|---|---|
| Partial listing of covered services | Care from a network provider | Care from an out-of-network provider * |
| **Dental Plan Parameters** | **Annual Maximums & Deductibles are combined across all tiers** | |
| - Annual maximum | $1,000 per calendar year | $1,000 per calendar year |
| - Individual Deductible (Applies to Basic Care, Special Care & Prosthetics) | $50 | $50 |
| - Family Deductible (Applies to Basic Care, Special Care & Prosthetics) | $150 | $150 |
| **Implant maximum** *included in annual maximum* | Unlimited | Unlimited |
| **Single Premium** | $48.07 | |
| **Coop Contribution** | -$57.51 | |
| **Emp Cost per month Single** | $0.00 | |
| **Emp Cost per pay period Single** | **$0.00** | |
| **Emp+Family Premium** | $147.46 | |
| **Coop Contribution** | -$67.44 | |
| **Emp Cost per month Family** | $80.02 | |
| **Emp Cost per pay period Family** | **$40.01** | |