Medica

Medical Rates for MAWSECO

Effective Date: 10/01/2024

	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	$845.56	$734.50	$612.10
Coop Contribution	-$700.00	-$700.00	-$700.00
Emp Cost per month Single	$145.56	$34.50	$0.00
Emp Cost per pay period Single	**$91.93**	**$21.79**	**$0.00**
Annual Amount into HSA/403b	**N/A**	**$0.00**	**$1,054.80**
Emp+Family Premium	$2,111.52	$1,834.22	$1,528.52
Coop Contribution	-$1,200.00	-$1,200.00	-$1,200.00
Emp Cost per month Family	$911.52	$634.22	$328.52
Emp Cost per pay period Family	**$575.70**	**$400.56**	**$207.49**
Annual Amount into HSA/403b	**N/A**	**$0.00**	**$0.00**

HealthPartners Dental

Effective Date: 7/01/2024

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	-$50.00	
Emp Cost per month Single	$0.00	
Emp Cost per pay period Single	**$0.00**	
Emp+Family Premium	$147.46	
Coop Contribution	-$50.00	
Emp Cost per month Family	$97.46	
Emp Cost per pay period Family	**$48.73**	