

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	-\$1,050.00	-\$1,050.00	-\$1,050.00
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	\$3,786.00	\$3,850.00
Emp+Family Premium	\$2,111.52	\$1,834.22	\$1,528.52
Coop Contribution	-\$2,000.00	-\$2,000.00	-\$2,000.00
Emp Cost per month Family	\$111.52	\$0.00	\$0.00
Emp Cost per pay period Family	\$55.76	\$0.00	\$0.00
Annual Amount into HSA/403b	N/A	\$1,989.36	\$5,657.76

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	-\$175.00	
Emp Cost per month Single	\$0.00	
Emp Cost per pay period Single	\$0.00	
Emp+Family Premium	\$147.46	
Coop Contribution	-\$175.00	
Emp Cost per month Family	\$0.00	
Emp Cost per pay period Family	\$0.00	