COBRA MEDICAL PLAN OFFERINGS

Any deductibles, copays, and coinsurance percentages shown in the chart below are amounts you are responsible for, before any District Contribution.

PLAN TYPE		COPAY PLAN		HSA PLAN	HSA PLAN	
NETWORK		VANTAGE PLUS ACO $350-$20-$30-20%	PARK NICOLLET AND HEALTHPARTNERS ACO $350-$20-$30-20%	MEDICA CHOICE PASSPORT	VANTAGE PLUS ACO	PARK NICOLLET AND HEALTHPARTNERS ACO
IN-NETWORK BENEFITS						
Monthly Premium	**Single**	$947.03	$926.14	$769.22	$623.79	$610.08
	Single + 1	$2,116.91	$2,070.03	$1,717.90	$1,391.59	$1,360.82
	Family	$2,453.85	$2,399.47	$1,991.14	$1,612.72	$1,577.04
Overall Deductible		$350 per person/$700 per family in-network and $1,650 per person/$3,300 per family for out-of-network services		$3,750 per person/ $7,500 per family in-network and $4,000 per person/$8,000 per family for out-of- network services	$6,000 per person/ $12,000 per family in-network and $7,000 per person/ $14,000 per family for out- of-network services	
Out-of-Pocket Limit		$2,500 per person/ $5,000 per family in-network and $5,000 per person/$10,000 per family for out-of-network services		$5,750 per person/ $11,500 per family in-network and $6,000 per person/$12,000 per family for out-of-network services	$7,500 per person/ $15,000 per family in-network and $9,000 per person/$18,000 per family for out-of-network services	
IF YOU VISIT A HEALTH CARE PROVIDER'S OFFICE OR CLINIC						
Primary Care Visit		$20 copay/visit. Deductible does not apply.		20% coinsurance	20% coinsurance	
Chiropractic Visit		$20 copay/visit. Deductible does not apply.		20% coinsurance	20% coinsurance	
Retail Health Visit		$20 copay/visit. Deductible does not apply.		20% coinsurance	20% coinsurance	
Virtual Care		$20 copay/visit. Deductible does not apply.		20% coinsurance	20% coinsurance	
Specialist Visit		$30 copay/visit. Deductible does not apply.		20% coinsurance	20% coinsurance	
Preventive Care/Screening/ Immunization		No charge. Deductible does not apply.		No charge. Deductible does not apply.	No charge. Deductible does not apply.	
IF YOU HAVE A TEST						
Diagnostic Test - Lab		No charge. Deductible does not apply		20% coinsurance	20% coinsurance	
Diagnostic Test - X-ray		No charge. Deductible does not apply		20% coinsurance	20% coinsurance	
Imaging (CT/PET Scans, MRI)		20% coinsurance		20% coinsurance	20% coinsurance	
IF YOU NEED DRUGS TO TREAT YOUR ILLNESS OR CONDITION						
Generic Drugs		Retail: $15/prescription Deductible does not apply. Mail order: $30/prescription Deductible does not apply.		Preventive: Designated preventive drugs: No charge. Deductible does not apply. Retail: 20% coinsurance Mail order: 20% coinsurance	Preventive: Designated preventive drugs: No charge. Deductible does not apply. Retail: 20% coinsurance Mail order: 20% coinsurance	
Preferred Brand Drugs		Retail: $30/prescription Deductible does not apply. Mail order: $60/prescription Deductible does not apply.		Preventive: Designated preventive drugs: No charge. Deductible does not apply. Retail: 20% coinsurance Mail order: 20% coinsurance	Preventive: Designated preventive drugs: No charge. Deductible does not apply. Retail: 20% coinsurance Mail order: 20% coinsurance	
Non-Preferred Brand Drugs		Retail: $45/prescription Deductible does not apply. Mail order: $90/prescription Deductible does not apply.		Preventive: Benefit does not apply. Retail: 30% coinsurance Mail order: 30% coinsurance	Preventive: Benefit does not apply. Retail: 30% coinsurance Mail order: 30% coinsurance	
Specialty Drugs		Preferred: $30 copay/prescription. Deductible does not apply. Non- Preferred: $45 copay/ prescription. Deductible does not apply.		Preferred: 20% coinsurance. No more than $200 copay/prescription. Non-Preferred: 30% coinsurance	Preferred: 20% coinsurance. No more than $200 copay/ prescription. Non-Preferred: 30% coinsurance	
IF YOU HAVE OUTPATIENT SURGERY						
Facility Fee (e.g., Ambulatory Surgery Center)		20% coinsurance		20% coinsurance	20% coinsurance	
Physician/surgeon fees		20% coinsurance		20% coinsurance	20% coinsurance	
IF YOU NEED IMMEDIATE MEDICAL ATTENTION						
Emergency Room Care		$75 copay/visit. Deductible does not apply.		20% coinsurance	20% coinsurance	
Emergency Medical Transportation		20% coinsurance		20% coinsurance	20% coinsurance	
Urgent Care		$20 copay/visit. Deductible does not apply.		20% coinsurance	20% coinsurance	
IF YOU HAVE A HOSPITAL STAY						
Facility Fee (e.g., Hospital Room)		20% coinsurance		20% coinsurance	20% coinsurance	
Physician/Surgeon Fees		20% coinsurance		20% coinsurance	20% coinsurance	
NETWORK INFORMATION						
Network Type		Accountable Care Organization network		National network	Accountable Care Organization network	
Network Area		Twin Cities metro area		Nationwide	Twin Cities metro area	
Referrals Needed		No referrals needed if you see an ACO network provider.		No referrals needed if you see a Medica Choice Passport network provider.	See any primary or specialty care provider in an ACO network provider without a referral.	

This is a summary of your benefits. Not all benefits are listed. For more details, contact Medica Member Services at 855-857-2045.