FULL-TIME KESPA SUPPORT STAFF
(bus drivers, paraprofessionals, food service, custodians-maintenance)
INSURANCE OPTIONS OVERVIEW
January 1, 2024 - December 31, 2024

	MESSA Choices $0 **Pak A**	**MESSA ABC - PLAN 1 (HSA Eligible)** **Pak C**	**MESSA D/V/L/LTD (Cash-in-Lieu)** **Pak B**
Employee Cost	**Your monthly employee cost are:** Single: $ 931.49 2 Person: $ 2042.77 Family: $ 2584.62	**Your monthly employee cost are:** Single: $ 708.89 2 Person: $ 1541.92 Family: $ 1961.34	**Your monthly employee cost are:** Single: $ 77.70 2 Person: $ 120.93 Family: $ 193.56
Cash-In-Lieu Payment	N/A	N/A	**Full-time employees** receive $60 monthly cash compensation. *Must provide proof of medical insurance coverage
Medical	**MESSA Choices** – Group #66578 • Deductible – None • Office visit - $5 copayment • Annual Preventive Health Care – 100% • Inpatient Hospital – 100% • Surgical Services – 100% • Hospital ER - $25 copayment* • Urgent care center - $10 copayment* • Diagnostic Lab & X-Ray – 100% • Basic Term Life - $5,000 *Copay may waived for accidental injury or admitted. **Above benefits relates to In-Network provider charges. Please see benefit summary for out of network provider charges.**	**MESSA ABC** – Group #66578 • **Deductible – $1,600 Single** **$3,200 2-Person** **$3,200 Family** Preventive Care – 100% not subject to deductible • Office Visits - subject to deductible • Inpatient Hospital - subject to deductible • Surgical Services - subject to deductible • Emergency Care -subject to deductible • Diagnostic Lab/X-Ray - subject to deductible • Basic Term Life - $5,000 After deductible above service covered at 100% **Above benefits relates to In-Network provider charges. Please see benefit summary for out of network provider charges.**	There is no medical coverage with this option
Prescription	**MESSA Saver Rx** Copayments range from $2 to $40* *Brand name Rx when a generic is available and medically appropriate subject to higher cost.	**MESSA ABC Rx** Copayments range from $2 to $40* *After deductible is met ABC Rx copayment applies. ***You pay full cost until your deductible is fully met.	There is no prescription coverage with this option
Dental	**Delta Dental** Group #6178-0010 $1,000 per person total per Benefit Year on services • Diagnostic/Preventive/X-ray paid at 80% • Basic dental services paid at 80% • Major dental services paid at 80% $1,500 per person total per lifetime on orthodontics • Orthodontic dental services paid at 80%. **Percentages are applied to Delta Dental's allowance for each service and may vary due to the dentist's network participation.**	**Delta Dental** Group #6178-0010 $1,000 per person total per Benefit Year on services • Diagnostic/Preventive/X-ray paid at 80% • Basic dental services paid at 80% • Major dental services paid at 80% $1,500 per person total per lifetime on orthodontics • Orthodontic dental services paid at 80%. **Percentages are applied to Delta Dental's allowance for each service and may vary due to the dentist's network participation.**	**Delta Dental** Group #6178-0011 $1,000 per person total per Benefit Year on services • Diagnostic/Preventive/X-ray paid at 100% • Basic dental services paid at 90% • Major dental services paid at 90% $1,500 per person total per lifetime on orthodontics • Orthodontic dental services paid at 90%. **Percentages are applied to Delta Dental's allowance for each service and may vary due to the dentist's network participation.**

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Continued…	**MESSA Choices $0** **Pak A**	**MESSA ABC - PLAN 1 (HSA Eligible)** **Pak C**	**MESSA D/V/L/LTD (Cash-in-Lieu)** **Pak B**
Vision	**Vision Service Plan** VSP2 • Examination - $6.50 copayment • Lenses - $18 copayment • Frames - $65 allowance • Lens enhancements - paid 100% (Of approved amount after copayment) • Elective contact lenses w/exam -$90 allowance One exam and one pair of eyeglass lenses or a 12-month supply of prescribed contact lenses once per plan year. **The above benefits are based on VSP participating/In-Network providers.** For details regarding coverage with non-participating provider, call 800.877.7195)	**Vision Service Plan** VSP2 • Examination - $6.50 copayment • Lenses - $18 copayment • Frames - $65 allowance • Lens enhancements - paid 100% (Of approved amount after copayment) • Elective contact lenses w/exam -$90 allowance One exam and one pair of eyeglass lenses or a 12-month supply of prescribed contact lenses once per plan year. **The above benefits are based on VSP participating/In-Network providers.** For details regarding coverage with non-participating provider, call 800.877.7195)	**Vision Service Plan** VSP3 • Examination – No copayment • Lenses - paid 100% (Of approved amount after copayment.) • Frames - $65 allowance • Lens enhancements - paid 100% (Of approved amount after copayment) • Elective contact lenses w/exam -$115 allowance One exam and one pair of eyeglass lenses or a 12-month supply of prescribed contact lenses once per plan year. **The above benefits are based on VSP participating/In-Network providers.** For details regarding coverage with non-participating provider, call 800.877.7195)
Life Insurance	$10,000 Life Insurance $10,000 Accidental Death & Dismemberment	$10,000 Life Insurance $10,000 Accidental Death & Dismemberment	$15,000 Life Insurance $15,000 Accidental Death & Dismemberment
Long Term Disability	66 2/3% of monthly salary, maximum of $5,000 Max Monthly Salary: $7,500 90 calendar day waiting period with modified fill • Includes pre-existing conditions waiver • Freeze of offsets • Cost of living benefit • Alcohol/drug & mental/nervous (same as any other illness)	66 2/3% of monthly salary, maximum of $5,000 Max Monthly Salary: $7,500 90 calendar day waiting period with modified fill • Includes pre-existing conditions waiver • Freeze of offsets • Cost of living benefit • Alcohol/drug & mental/nervous (same as any other illness)	66 2/3% of monthly salary, maximum of $5,000 Max Monthly Salary: $7,500 90 calendar day waiting period with modified fill • Includes pre-existing conditions waiver • Freeze of offsets • Cost of living benefit • Alcohol/drug & mental/nervous (same as any other illness)
Footnotes			
	Part-time employee insurance qualifications: 15-29.75 hours per week Part-time employees pay 100% of the monthly premium. Employee contributions will be deducted pre-tax unless otherwise requested. **Above MESSA premiums effective January 1, 2023**	Part-time employee insurance qualifications: 15-29.75 hours per week Part-time employees pay 100% of the monthly premium. Employee contributions will be deducted pre-tax unless otherwise requested. **Above MESSA premiums effective January 1, 2023**	Part-time employee insurance qualifications: 15-29.75 hours per week Part-time employees pay 100% of the monthly premium. Employee contributions will be deducted pre-tax unless otherwise requested. **Above MESSA premiums effective January 1, 2023**

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	MESSA Choices $500/$1,000 **Deductible w/ 10% Coinsurance** **Pak D**	**MESSA ABC Plan 1** **Deductible w/ 20% Coinsurance (HSA Eligible)** **Pak E**
Employee Cost	**Your monthly employee cost are:** Single: $ 737.63 2 Person: $ 1606.58 Family: $ 2041.81	**Your monthly employee cost are:** Single: $ 650.01 2 Person: $ 1409.45 Family: $ 1796.48
Cash In-Lieu Payment	N/A	N/A
Medical	**MESSA Choices** – Group #66578 • **Deductible – $500 Single** **$1,000 2-Person** **$1,000 Family** • Office visit - $20 copayment • Annual Preventive Health Care – 100% • Inpatient Hospital – 90% • Surgical Services – 90% • Hospital ER - $50 copayment* • Urgent care center - $25 copayment* • Diagnostic Lab & X-Ray – 90% • Basic Term Life - $5,000 **After deductible is met, 10% Co-Insurance** *Copay may waived for accidental injury or admitted. If copay is waived, coinsurance may apply after deductible is met. **Above benefits relates to In-Network provider charges. Please see benefit summary for out of network provider charges.**	**MESSA ABC** – Group #66578 • **Deductible – $1,600 Single** **$3,200 2-Person** **$3,200 Family** Preventive Care – 100% not subject to deductible • Office Visits - subject to deductible • Inpatient Hospital - subject to deductible • Surgical Services - subject to deductible • Emergency Care -subject to deductible • Diagnostic Lab/X-Ray - subject to deductible • Basic Term Life - $5,000 **After deductible is met, 20% Co-Insurance** *Copay may waived for accidental injury or admitted. If copay is waived, coinsurance may apply after deductible is met. **Above benefits relates to in-network provider charges. Please see benefit summary for out of network provider charges.**
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