FULL-TIME KESPA SUPPORT STAFF
(bus drivers, paraprofessionals, food service, custodians-maintenance)
INSURANCE OPTIONS OVERVIEW
January 1, 2023 - December 31, 2023

	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: $ 290.96 2 Person: $ 698.17 Family: $ 834.16	**Your monthly employee cost are:** Single: $ 15.37 2 Person: $ 117.01 Family: $ 77.15	**Your monthly employee cost are:** Single: $ 7.87 2 Person: $ 12.19 Family: $ 19.46
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 – $1,500 Single** **$3,000 2-Person** **$3,000 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	**<u>Vision Service Plan</u>** <u>VSP2</u> • 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 <u>or</u> 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)	**<u>Vision Service Plan</u>** <u>VSP2</u> • 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 <u>or</u> 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)	**<u>Vision Service Plan</u>** <u>VSP3</u> • 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 <u>or</u> 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			
	Full-time employee insurance qualifications: 1.0 FTE (30 or more hours per week) The above cost is based on the employer paying the allowed PA 152 limit and the employee paying the difference in the MESSA Choices monthly premium. **PA 152 Employer limit monthly amount:** **Single: $ 616.62** **2 Person: $ 1289.55** **Family: $ 1681.70** **<u>Above MESSA premiums effective January 1, 2023</u>**	Full-time employee insurance qualifications: 1.0 FTE (30 or more hours per week) The above cost is based on the employer paying the allowed PA 152 limit and the employee paying the difference in the MESSA ABC monthly premium. **PA 152 Employer limit monthly amount:** **Single: $ 616.62** **2 Person: $ 1289.55** **Family: $ 1681.70** **<u>Above MESSA premiums effective January 1, 2023</u>**	Full-time employee insurance qualifications: 1.0 FTE (30 or more hours per week) The above cost is based on the employee paying 10% of the MESSA monthly PAK B premium (premium amounts are listed below). **Single: $ 78.70** **2 Person: $ 121.93** **Family: $ 194.56** **<u>Above MESSA premiums effective January 1, 2023</u>**

This comparison is intended as an easy-to-read summary. An official description of benefits can be found at MESSA.org. All cost and options are subject to change pending contract negotiations.

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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: $ 102.74 2 Person: $ 274.68 Family: $ 307.15	**Your monthly employee cost are:** Single: $ 15.37 2 Person: $ 23.72 Family: $ 37.97
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 – $1,500 Single** **$3,000 2-Person** **$3,000 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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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)
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