

PART-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	<u>Your monthly employee cost are:</u> Single: \$ 907.58 2 Person: \$ 1,987.72 Family: \$ 2,515.86	<u>Your monthly employee cost are:</u> Single: \$ 691.45 2 Person: \$ 1,501.44 Family: \$ 1,910.73	<u>Your monthly employee cost are:</u> Single: \$ 78.70 2 Person: \$ 121.93 Family: \$ 194.56
Cash-In-Lieu Payment	N/A	N/A	Full-time employees receive \$60 monthly cash compensation. *Must provide proof of medical insurance coverage
Medical	<u>MESSA Choices – Group #66578</u> <ul style="list-style-type: none"> • 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 <p>*Copay may waived for accidental injury or admitted.</p> <p>Above benefits relates to In-Network provider charges. Please see benefit summary for out of network provider charges.</p>	<u>MESSA ABC – Group #66578</u> <ul style="list-style-type: none"> • Deductible – \$1,500 Single \$3,000 2-Person \$3,000 Family <p>Preventive Care – 100% not subject to deductible</p> <ul style="list-style-type: none"> • 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 <p>After deductible above service covered at 100%</p> <p>Above benefits relates to In-Network provider charges. Please see benefit summary for out of network provider charges.</p>	There is no medical coverage with this option
Prescription	<u>MESSA Saver Rx</u> Copayments range from \$2 to \$40* *Brand name Rx when a generic is available and medically appropriate subject to higher cost.	<u>MESSA ABC Rx</u> 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	<u>Delta Dental Group #6178-0010</u> \$1,000 per person total per Benefit Year on services <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Orthodontic dental services paid at 80%. <p>Percentages are applied to Delta Dental's allowance for each service and may vary due to the dentist's network participation.</p>	<u>Delta Dental Group #6178-0010</u> \$1,000 per person total per Benefit Year on services <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Orthodontic dental services paid at 80%. <p>Percentages are applied to Delta Dental's allowance for each service and may vary due to the dentist's network participation.</p>	<u>Delta Dental Group #6178-0011</u> \$1,000 per person total per Benefit Year on services <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Orthodontic dental services paid at 90%. <p>Percentages are applied to Delta Dental's allowance for each service and may vary due to the dentist's network participation.</p>

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Vision	<p><u>Vision Service Plan VSP2</u></p> <ul style="list-style-type: none"> 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 <p>One exam and one pair of eyeglass lenses <u>or</u> a 12-month supply of prescribed contact lenses once per plan year.</p> <p>The above benefits are based on VSP participating/In-Network providers. For details regarding coverage with non-participating provider, call 800.877.7195)</p>	<p><u>Vision Service Plan VSP2</u></p> <ul style="list-style-type: none"> 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 <p>One exam and one pair of eyeglass lenses <u>or</u> a 12-month supply of prescribed contact lenses once per plan year.</p> <p>The above benefits are based on VSP participating/In-Network providers. For details regarding coverage with non-participating provider, call 800.877.7195)</p>	<p><u>Vision Service Plan VSP3</u></p> <ul style="list-style-type: none"> 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 <p>One exam and one pair of eyeglass lenses <u>or</u> a 12-month supply of prescribed contact lenses once per plan year.</p> <p>The above benefits are based on VSP participating/In-Network providers. For details regarding coverage with non-participating provider, call 800.877.7195)</p>
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	<p>66 2/3% of monthly salary, maximum of \$5,000 Max Monthly Salary: \$7,500</p> <p>90 calendar day waiting period with modified fill</p> <ul style="list-style-type: none"> Includes pre-existing conditions waiver Freeze of offsets Cost of living benefit Alcohol/drug & mental/nervous (same as any other illness) 	<p>66 2/3% of monthly salary, maximum of \$5,000 Max Monthly Salary: \$7,500</p> <p>90 calendar day waiting period with modified fill</p> <ul style="list-style-type: none"> Includes pre-existing conditions waiver Freeze of offsets Cost of living benefit Alcohol/drug & mental/nervous (same as any other illness) 	<p>66 2/3% of monthly salary, maximum of \$5,000 Max Monthly Salary: \$7,500</p> <p>90 calendar day waiting period with modified fill</p> <ul style="list-style-type: none"> Includes pre-existing conditions waiver Freeze of offsets Cost of living benefit Alcohol/drug & mental/nervous (same as any other illness)
Footnotes			
	<p>Part-time employee insurance qualifications: 15-29.75 hours per week</p> <p>Part-time employees pay 100% of the monthly premium.</p> <p>Employee contributions will be deducted pre-tax unless otherwise requested.</p> <p><u>Above MESSA premiums effective January 1, 2023</u></p>	<p>Part-time employee insurance qualifications: 15-29.75 hours per week</p> <p>Part-time employees pay 100% of the monthly premium.</p> <p>Employee contributions will be deducted pre-tax unless otherwise requested.</p> <p><u>Above MESSA premiums effective January 1, 2023</u></p>	<p>Part-time employee insurance qualifications: 15-29.75 hours per week</p> <p>Part-time employees pay 100% of the monthly premium.</p> <p>Employee contributions will be deducted pre-tax unless otherwise requested.</p> <p><u>Above MESSA premiums effective January 1, 2023</u></p>

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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	<u>Your monthly employee cost are:</u> Single: \$ 719.36 2 Person: \$ 1,564.23 Family: \$ 1,988.85	<u>Your monthly employee cost are:</u> Single: \$ 634.29 2 Person: \$ 1,372.83 Family: \$ 1,750.67
Cash In-Lieu Payment	N/A	N/A
Medical	<u>MESSA Choices – Group #66578</u> <ul style="list-style-type: none"> • 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 <u>After deductible is met, 10% Co-Insurance</u> *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.	<u>MESSA ABC – Group #66578</u> <ul style="list-style-type: none"> • Deductible – \$1,500 Single \$3,000 2-Person \$3,000 Family Preventive Care – 100% not subject to deductible <ul style="list-style-type: none"> • 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 <u>After deductible is met, 20% Co-Insurance</u> *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.
Prescription	<u>MESSA Saver Rx</u> Copayments range from \$2 to \$40* *Brand name Rx when a generic is available and medically appropriate subject to higher cost.	<u>MESSA ABC Rx</u> Copayments range from \$2 to \$40* *After deductible is met ABC Rx copayment applies. ***You pay full cost until your deductible is fully met.
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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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