April 4, 2018

MSEA Insurance Comparison

These plans will be offered to all employees in the MSEA bargaining unit for the 2018-2019 school year (July 1, 2018 – June 30, 2019).

Open Enrollment for participation in the Public Education Health Trust will be from May 1, 2018 to June 15, 2018. ***If you are currently enrolled and do not wish to change plans you do not need to take any action for your health insurance to continue.*** If you are looking to change your coverage; whether you are currently waived and wish to enroll, currently enrolled and wish to waive, currently enrolled and wish to change plan you will need to complete the open enrollment form. The form must be turned into the Trust office no later than June 15th. Please also submit a copy of the form to the District payroll office. Forms will be emailed directly to employees by the District or you may download the form from the MSEA webpage at www.mseak.org/health-insurance.html as soon as the forms are available.

If you are currently enrolled and are switching plans, please list the qualified dependents for whom you are providing coverage. If the dependents are currently enrolled on your plan you will not need to resubmit required documentation. If they are new dependents, please include the required certificates.

If you are currently waived, or are newly eligible and are enrolling, please list all qualified dependents and submit the required appropriate certificates.

The open enrollment form and dependent verification certificates (required for new enrollments) are required to be received by the Trust office no later than 4:00pm on June 15th to be considered for a July 1, 2018 effective date. Material received after that date/time will not be considered until the next open enrollment period in 2019.

	Plan A/B with Ortho	**Plan C/B with Ortho**	**Plan F/B with Ortho**
Total Plan Cost	$25,519.20	$24,295.20	$22,219.20
District's share	$20,928.00	$20,928.00	$20,928.00
Employee's share	$4,591.20	$3,367.20	$1,291.20
Paycheck deduction (18 paycheck deductions; Sept 15 – May 30)	$255.07	$187.07	$71.73

	Plan A/B with Ortho	**Plan C/B with Ortho**	**Plan F/B with Ortho**
Individual/Family Deductible	$100 / $300	$500 / $1,500	$1,500 / $3,000
Coinsurance %	Preferred 80% to $5,000; Non-Preferred Facility and Providers Payable amount up to 125% of the Medicare equivalent rate	Preferred 80% to $10,000; Non-Preferred Facility and Providers Payable amount up to 125% of the Medicare equivalent rate	Preferred 80% to $15,000; Non-Preferred Facility and Providers Payable amount up to 125% of the Medicare equivalent rate
Individual/Family Max Out of Pocket	$1,000 plus deductible / $3,000 plus deductible	$2,000 plus deductible / $6,000 plus deductible	$3,000 plus deductible / $6,000 plus deductible
Chiropractic	Subject to deductible and coinsurance; up to 20 visits per calendar year	Subject to deductible and coinsurance; up to 20 visits per calendar year	Subject to office visit copay or deductible/coinsurance; up to 20 visits per calendar year
Primary Care Office Visit Co-Pay	N/A	N/A	$25 (1st 6 visits per calendar year)
Prescriptions - retail (Generic medications required when available)	$12 / $25 / $50 30-day supply	$17 / $30 / $60 30-day supply	$17 / $30 / $60 30-day supply
Prescriptions - mail order (Generic medications required when available)	$24 / $50 / $100 90-day supply	$34 / $60 / $120 90-day supply	$34 / $60 / $120 90-day supply
Specialty Medication (Not including oncology medications)	50% co-payment per prescription with a per prescription maximum of $100 Value/$400 Formulary/$600 Non-Formulary	50% co-payment per prescription with a per prescription maximum of $100 Value/$400 Formulary/$600 Non-Formulary	50% co-payment per prescription with a per prescription maximum of $100 Value/$400 Formulary/$600 Non-Formulary
Preventative Care (Well baby and routine cancer screenings)	Paid at 100%	Paid at 100%	Paid at 100%
Emergency Room Deductible (waived if admitted)	$500	$500	$500
Bridge Health or miChoice	100% no deductible	100% no deductible	100% no deductible
Teladoc	No cost to the member. Prescriptions subject to prescription benefit.	No cost to the member. Prescriptions subject to prescription benefit.	No cost to the member. Prescriptions subject to prescription benefit.

Dental Benefit is the same for all plans	
Deductible	$75 per person or $225 per family
Maximum (per calendar year)	$3,000 per person (does not apply to preventative care services for covered persons age 18 and under)
Preventative Care	100% up to the Usual and Customary (two visits per person per year)
Basic	80% subject to deductible and up to Usual and Customary
Major	50% subject to deductible and up to Usual and Customary
Orthodontia (per lifetime)	50% up to $2000 per person

Vision Benefit (In VSP Network) is the same for all plans	
Co-Pay	Exam $25; Materials $25
Annual Exam	Paid-in-Full every calendar year (after co-payment)
Lenses (single vision, lined bifocal, lined trifocal, and Lenticular lenses)	Paid-in-Full every calendar year (after co-payment). Anti-reflective coating covered in full.
Frames	Paid-in-Full up to $195 every calendar year (after co-payment) OR Two (2) pairs of frames every other calendar year (after co-payment)
Contact Lenses (instead of spectacle lenses and frame)	Necessary – Paid-in-Full (after co-payment); Specific benefit criteria must be met for Necessary Contact Lenses. Eligibility is determined by the VSP doctor at the time of service. Elective – paid up to $130. Contac lens fitting and evaluation exam is covered after a $60 copay.