Premium and Benefit Comparison - Medical/Rx
Prepared for: Holton Public Schools - All Staff
Effective Date: January 1, 2022

Williams & Company, LLC.
EMPLOYEE BENEFITS

Medical Plan		MESSA	MESSA	BCBSM Simply Blue HSA	BCBSM Simply Blue HSA	Priority Health HSA PPO 100%	Priority Health HSA PPO 90%	Priority Health HSA HMO 100%	HAP HSA PPO 100%	HAP HSA EPO 100%
Plan Type		ABC Plan 1 (7V)	ABC Plan 2 (9G)							
In Network Deductible		$1,400/$2,800	$2,000/$4,000	$1,400/$2,800	$2,000/$4,000	$1,400 / $2,800	$2,000 / $4,000	$2,000 / $4,000	$1,400/$2,800	$2,000 / $4,000
In Network Coinsurance		100%	90%	100%	90%	100%	90%	100%	100%	100%
In Network Out-pocket Max		$2,400/$4,800	$4,000/$7,050	$4,000/$8,000	$4,000/$8,000	$2,800 / $5,600	$4,000 / $8,000	$4,000 / $8,000	$2,800 / $5,600	$3,000 / $6,000
Out of Network Deductible		undefined	undefined	$2,800 / $5,600	$4,000 / $8,000	$2,800 / $5,600	$4,000 / $8,000	n/a	$2,800 / $5,600	n/a
Out Network Coinsurance		undefined	undefined	80%	70%	80%	70%	n/a	80%	n/a
Out Network Coinsurance Max		undefined	undefined	$8,000 / $16,000	$8,000 / $16,000	$5,600 / $11,200	$8,000 / $16,000	n/a	$5,600 / $11,200	n/a
		In-network	In-network	In-network	In-network	In-Network	In-Network	In-Network	In-network	In-Network
Office Visit-PCP		100% after deduct	90% after deduct	100% after deduct	90% after deduct	100% after deductible	90% after deductible	100% after deductible	100% after deduct	100% after deductible
Office Visit- Specialist		100% after deduct	90% after deduct	100% after deduct	90% after deduct	100% after deductible	90% after deductible	100% after deductible	100% after deduct	100% after deductible
Urgent Care		100% after deduct	90% after deduct	100% after deduct	90% after deduct	100% after deductible	90% after deductible	100% after deductible	100% after deduct	100% after deductible
Emergency Room		100% after deduct	90% after deduct	100% after deduct	90% after deduct	100% after deductible	90% after deductible	100% after deductible	100% after deduct	100% after deductible
Ambulance		100% after deduct	90% after deduct	100% after deduct	90% after deduct	100% after deductible	90% after deductible	100% after deductible	100% after deduct	100% after deductible
Hospital		100% after deduct	90% after deduct	100% after deduct	90% after deduct	100% after deductible	90% after deductible	100% after deductible	100% after deduct	100% after deductible
Chiropractic Care		100% after deduct, up to 38-yr	90% after deduct, up to 38-yr	100% after deduct, up to 12/yr	90% after deduct, up to 12/yr	100% after deductible, up to 30	90% after deductible, up to 30 visits/yr	100% after deductible, up to 30 visits/yr	100% after deductible, up to 20	100% after deductible, up to 20
High Tech Imaging (MRI, PET, etc)		100%	90%	100% after deduct	90% after deduct	100% after deductible	90% after deductible	100% after deductible	100% after deduct	100% after deductible
DME/P&O		100%	90%	100% after deduct	90% after deduct	100% after deductible	90% after deductible	100% after deductible	100% after deduct	100% after deductible
Prescription Drug Copay (after deductible on HSA plans)		$0/$2/$10/$20/$40 ABC Rx	$0/$2/$10/$20/$40 ABC Rx	$10/$40/$80 2x mail order	$10/$40/$80 2x mail order	$10/$40 2x mail	$10/$40 2x mail	$10/$40 2x mail	$10/$40/$80 2x mail order	$10/$40/$80 2x mail order
Enrollment	**Census**									
Single	**20**	$790.31	$690.74	$648.85	$544.11	$676.61	$559.25	$536.52	$732.31	$655.95
Double	**6**	$1,778.19	$1,554.16	$1,557.24	$1,305.85	$1,522.38	$1,258.32	$1,180.45	$1,647.70	$1,475.89
Family	**27**	$2,212.86	$1,934.06	$1,946.56	$1,632.31	$1,894.50	$1,565.90	$1,556.12	$2,050.47	$1,836.66
Projected Monthly Premium		$86,222.56	$75,359.38	$74,877.56	$62,789.67	$73,817.98	$61,014.22	$59,828.34	$79,895.09	$71,564.16
Projected Annual Premium		$1,034,670.72	$904,312.56	$898,530.72	$753,476.04	$885,815.76	$732,170.64	$717,940.08	$958,741.08	$858,769.92

Note 1: Premiums include estimated Federal and State taxes & fees

Please note: This information is intended to summarize and illustrate the benefits, rates, taxes, and other fees associated with purchase of the proposed plans. These descriptions do not modify any definitions expressly stated in any contracts of insurance. Tax calculations reflect the State and Federal tax assumptions used by the insurance companies and included in their proposed rates. Employers should consult with legal counsel regarding compliance with state and federal laws.

Premium and Benefit Comparison
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Williams & Company, LLC.
EMPLOYEE BENEFITS

Item	MESSA	UNUM	Companion Life	BCBSM	
	Delta Dental	Elite Plan (Passive PPO)	Dental by Design	Blue Dental PPO	
Deductible	None	$50 (family max 3x)	$50 (family max 3x)	None	$50 (family max 3x)
Deductible apply to Class I?	N/A	No	No	N/A	
Diagnostic & Preventive Services	80%	80%	80%	100%	80% of approved amount
Basic Services	80%	80%	80%	80%	60% of approved amount
Major Restorative Services	80%	60%	80%	60%	40% of approved amount
Annual Max Benefit (per person)	UCR	$1,000	$1,000	$1,500	
Orthodontics	80%	Not Covered	50%	50%	50% of approved amount
Orthodontia Max Benefit (per lifetime)	UCR	n/a	$1,000	$1,500	

Rates Effective	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Employee	$36.78	$31.47	$45.18	$31.33
Employee & Spouse	$70.31	$59.75	$87.63	$62.66
Family	$143.43	$128.59	$148.05	$109.65

*NOTE: MESSA rates shown reflect the average rate currently charged between Adminstrators, Support Staff and Teachers (with and with-out medical coverage).

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Item	MESSA	BCBSM	UNUM	Companion Life
	VSP 2	Blue Vision	TLC Vision	Vision by Design
Exam	12 months	12 months	12 months	12 months
Lenses	12 months	12 months	12 months	12 months
Frames	12 months	12 months	12 months	12 months
	In Network	In Network	In Network	In Network
Exam	$6.50 copay	$10 copay	$10 copay	$15 copay
Materials				
Single vision lenses	$18 copay			
Bifocal lenses	$18 copay		$25 copay (one copay applies to both lenses and frames)	
Trifocal lenses	$18 copay	$25 copay (one copay applies to **both** lenses and frames)		
Lenticular lenses	$18 copay		$80 allowance	
Progressive lenses	not covered	undefined	$70 allowance	
Frames	covered up to $65 retail allowance, 20% off balance over $65.	$130 allowance that is applied toward frames less $25 copay (one copay applies to both lenses and frames)	$130 allowance that is applied toward frames less $10 copay (one copay applies to both lenses and frames)	$150 allowance per year (less $15 copay) that is applied toward all optical items sold in an optical shop including frames, lenses, lens treatments, contact lenses, etc.
Contact Lenses	covered up to $90 retail allowance, 15% discount (conventional) or 10% discount (disposable) off balance over $90. Medically necessary $0 copay.	$130 allowance applied to contact lens exam (fitting and materials) and the contact lenses. Medically necessary contact lenses covered with $25 copay.	$130 allowance applied to contact lens exam (fitting and materials) and the contact lenses. Medically necessary contact lenses covered up to $210 allowance.	
Rates Effective	1/1/2022	1/1/2022	1/1/2022	1/1/2022
EE	$5.39	$5.07	$5.81	$7.30
EE+1	$11.54	$10.14	$11.24	$15.40
FAM	$17.37	$16.84	$19.37	$22.85

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