

**Ionía County ISD - HEALTH INSURANCE RATES 1/1/25 - 12/31/25**

IIEA Plans - MESSA						
	Plan# 1 OLD	Plan# 1 NEW	Plan# 2 OLD	Plan# 2 NEW	Plan# 3 OLD	Plan# 3 NEW
	BCBS MESSA ABC Plan 1 - 0% (H.S.A.)	BCBS MESSA ABC Plan 1 - 0% (H.S.A.)	BCBS MESSA ABC Plan 1-10% (H.S.A.)	BCBS MESSA ABC Plan 2-10% (H.S.A.)	BCBS MESSA Choices	BCBS MESSA Choices
Plan Highlights	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network
Individual Deductible	\$1,650.00	\$1,650.00	\$1,650.00	\$2,000.00	\$500.00	\$1,000.00
Family Deductible	\$3,300.00*	\$3,300.00*	\$3,300.00*	\$4,000.00*	\$1,000.00	\$2,000.00
Coinsurance (Employee Pays)	0%	0%	10%	10%	0%	0%
Individual Coinsurance Max	N/A	N/A	N/A	N/A	N/A	N/A
Family Coinsurance Max	N/A	N/A	N/A	N/A	N/A	N/A
Individual Out of Pocket Max	\$2,600.00	\$3,650.00	\$3,600.00	\$5,000.00	\$2,500.00	\$4,000.00
Family Out of Pocket Max	\$5,200.00	\$7,300.00	\$7,200.00	\$8,300.00	\$5,000.00	\$8,000.00
<b>Covered Benefits</b>						
Preventative Care	100%	100%	100%	100%	100%	100%
Primary Care Physician Office Visit	100% after deductible	100% after deductible	90% after deductible	90% after deductible	\$20 Copay	\$20 Copay
Specialist Office Visit	100% after deductible	100% after deductible	90% after deductible	90% after deductible	\$20 Copay	\$20 Copay
Online Visit	100% after deductible	100% after deductible	90% after deductible	90% after deductible	\$20 Copay	\$20 Copay
Urgent Care Visit	100% after deductible	100% after deductible	90% after deductible	90% after deductible	\$25 Copay	\$25 Copay
Emergency Room	100% after deductible	100% after deductible	90% after deductible	90% after deductible	\$50 Copay	\$50 Copay
Chiropractic	100% after deductible (Maximum 38 visits per year, including massage therapy)	100% after deductible (Maximum 38 visits per year, including massage therapy)	90% after deductible (Maximum 38 visits per year, including massage therapy)	90% after deductible (Maximum 38 visits per year, including massage therapy)	\$20 copay may apply; 100% after deductible (Maximum 38 visits per year, including massage therapy)	\$20 copay may apply; 100% after deductible (Maximum 38 visits per year, including massage therapy)
PT/OT/ST Combined	100% after deductible (Combined limit to 60 visits per year)	100% after deductible (Combined limit to 60 visits per year)	90% after deductible (Combined limit to 60 visits per year)	90% after deductible (Combined limit to 60 visits per year)	100% after deductible (Combined limit to 60 visits per year)	100% after deductible (Combined limit to 60 visits per year)
Massage Therapy	Included in Chiropractic	Included in Chiropractic	Included in Chiropractic	Included in Chiropractic	Included in Chiropractic	Included in Chiropractic
<b>Prescription Drugs</b>						
Generic	Free, \$2 or \$10 after	Free or \$10 Copay after	Free, \$2 or \$10 after	Free or \$10 Copay after	\$2 or \$10 Copay	\$10 Copay
Preferred Brand	\$20 or \$ 40 Copay after	\$40 Copay after deductible	\$20 or \$ 40 Copay after	20% coinsurance (\$40 min -	\$20 or \$ 40 Copay	20% coinsurance (\$40 min -
Non-Preferred Brand	\$20 or \$ 40 Copay after	\$80 Copay after deductible	\$20 or \$ 40 Copay after	20% coinsurance (\$60 min -	\$20 or \$ 40 Copay	20% coinsurance (\$60 min -
Preferred Specialty Generic	Free, \$2 or \$10 after deductible	20% coinsurance (\$0 min - \$150 max) after deductible	Free, \$2 or \$10 after deductible	Pricing included in one of the above categories	\$2 or \$10 Copay	Pricing included in one of the above categories
Preferred Specialty Brand	\$20 or \$ 40 Copay after deductible	20% coinsurance (\$0 min - \$150 max) after deductible	\$20 or \$ 40 Copay after deductible		\$20 or \$ 40 Copay	
Non-Preferred Specialty	\$20 or \$ 40 Copay after deductible	20% coinsurance (\$0 min - \$300 max) after deductible	\$20 or \$ 40 Copay after deductible		\$20 or \$ 40 Copay	
Mail Order Prescriptions (90 Days)	2x (includes retail or mail)	3x 1-month supply; retail or mail after deductible	2x (includes retail or mail)	2.5x 1-month supply; retail or mail after deductible	2x (includes retail or mail)	2.5x 1-month supply; retail or mail
<b>Employee Per Payroll Premiums (Withheld on the 1st &amp; 2nd pay of the month for 24 Pays)</b>						
Employee	\$134.59	\$89.05	\$100.19	\$48.06	\$197.51	\$143.57
2-Person	\$352.92	\$250.45	\$275.53	\$158.23	\$494.51	\$373.11
Family	\$398.88	\$271.37	\$302.57	\$156.60	\$575.08	\$424.01

\*The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.