2023 Health Plan Highlights

All Mesquite Independent School District employees have four plan options. Each includes a wide range of wellness benefits.

	PPO PLAN B (FORMERLY AC HD)		EPO PLAN A (FORMERLY AC PRIMARY)		EPO PLAN B (FORMERLY AC PRIMARY +)		PPO PLAN A (CLOSED TO NEW ENROLLEES)	
MONTHLY PREMIUMS								
	TOTAL PREMIUM	YOUR PREMIUM	TOTAL PREMIUM	YOUR PREMIUM	TOTAL PREMIUM	YOUR PREMIUM	TOTAL PREMIUM	YOUR PREMIUM
EMPLOYEE ONLY	$422.00	$122.00	$410.00	$110.00	$515.00	$215.00	$1,013.00	$713.00
EMPLOYEE AND SPOUSE	$1,187.00	$887.00	$1,157.00	$857.00	$1,259.00	$959.00	$2,402.00	$2,102.00
EMPLOYEE AND CHILD(REN)	$757.00	$457.00	$738.00	$438.00	$829.00	$529.00	$1,507.00	$1,207.00
EMPLOYEE AND FAMILY	$1,419.00	$1,119.00	$1,384.00	$1,084.00	$1,584.00	$1,284.00	$2,841.00	$2,541.00
TYPE OF COVERAGE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK COVERAGE ONLY		IN-NETWORK COVERAGE ONLY		IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE								
INDIVIDUAL/FAMILY	$3,000/$6,000	$5,500/$11,000	$2,500/$5,000		$1,200/$3,600		$1,000/$3,000	$2,000/$6,000
COINSURANCE (MEMBER PAYS)	30%*	50%*	30%*		20%*		20%*	40%*
ANNUAL OUT-OF-POCKET MAXIMUM								
INDIVIDUAL/FAMILY	$7,050/$14,100	$20,250/$40,500	$8,150/$16,300		$6,900/$13,800		$7,900/$15,800	$23,700/$47,400
COPAYS/COINSURANCE								
PRIMARY CARE OFFICE VISIT	30%*	50%*	$30 copay		$30 copay		$30 copay	40%*
SPECIALIST OFFICE VISIT	30%*	50%*	$70 copay		$70 copay		$70 copay	40%*
URGENT CARE	30%*	50%*	$50 copay		$50 copay		$50 copay	40%*
EMERGENCY CARE	30%*	Preferred provider benefit applies	30%*		20%*		$250 copay/visit, then 20%*	Preferred provider benefit applies
TELADOC VIRTUAL VISIT	$42 copay	$42 copay	$12 copay		$12 copay		$12 copay	$12 copay
PHARMACY								
RX DEDUCTIBLE	Integrated with Medical Deductible		Integrated with Medical Deductible		$200 brand deductible		$200 brand deductible	
PRESCRIPTION DRUGS								
ROUTINE PREVENTATIVE	Covered in Full		Covered in Full		Covered in Full		Covered in Full	
GENERICS	20%*		$15 copay		$15 copay		$20 copay	
BRAND NAME	25%*		30%*		25%*		25%* $40 min/$80 max	
NON-PREFERRED BRAND NAME	50%*		50%*		50%*		50%* $100 min/$200 max	
INSULIN OUT-OF-POCKET COSTS	25%*		$25 copay for 31-day supply; $75 for 61-90 day supply		$25 copay for 31-day supply; $75 for 61-90 day supply		$25 copay for 31-day supply; $75 for 61-90 day supply	
MAIL ORDER PRESCRIPTION DRUGS (90-DAY SUPPLY)								
ROUTINE PREVENTATIVE	Covered in Full		Covered in Full		Covered in Full		Covered in full	
GENERIC	20%*		$45 copay		$45 copay		$45 copay	
PREFERRED BRAND NAME	25%*		30%*		25%*		25%* $105 min/ $210 max	
NON-PREFERRED BRAND NAME	50%*		50%*		50%*		50%* $215 min/$430 max	
SPECIALTY (30 DAY SUPPLY)	20%*		$0 if Flex Access eligible; 30%*		$0 if Flex Access eligible; 30%*		$0 if Flex Access eligible; 30%* $200 min/$900 max	

*After deductible

*After deductible

Last updated 8/3/23