2024-2025 Health Plan Highlights

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

	PPO – HIGH DEDUCTIBLE PLAN		EPO – LOW PLAN		EPO – HIGH PLAN	
MONTHLY PREMIUMS						
	TOTAL PREMIUM	YOUR PREMIUM	TOTAL PREMIUM	YOUR PREMIUM	TOTAL PREMIUM	YOUR PREMIUM
EMPLOYEE ONLY	$570.06	$140.00	$585.16	$135.00	$624.85	$247.00
EMPLOYEE AND SPOUSE	$1,197.12	$1,020.00	$1,228.83	$986.00	$1,312.19	$1,103.00
EMPLOYEE AND CHILD(REN)	$1,104.57	$605.00	$1,133.84	$634.00	$1,210.75	$711.00
EMPLOYEE AND FAMILY	$1,839.14	$1,389.00	$1,887.87	$1,438.00	$2,015.93	$1,566.00
TYPE OF COVERAGE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK COVERAGE ONLY		IN-NETWORK COVERAGE ONLY	
DEDUCTIBLE						
INDIVIDUAL/FAMILY	$3,200/$6,400	$5,500/$11,000	$2,500/$5,000		$1,200/$3,600	
COINSURANCE (MEMBER PAYS)	30%*	50%*	30%*		20%*	
ANNUAL OUT-OF-POCKET MAXIMUM						
INDIVIDUAL/FAMILY	$7,050/$14,100	$20,250/$40,500	$8,150/$16,300		$6,900/$13,800	
COPAYS/COINSURANCE						
PRIMARY CARE OFFICE VISIT	30%*	50%*	$30 copay		$30 copay	
SPECIALIST OFFICE VISIT	30%*	50%*	$70 copay		$70 copay	
URGENT CARE	30%*	50%*	$50 copay		$50 copay	
EMERGENCY CARE	30%*	Preferred provider benefit applies	30%*		20%*	
TELADOC VIRTUAL VISIT	$42 copay	$42 copay	$12 copay		$12 copay	
PHARMACY						
RX DEDUCTIBLE	Integrated with Medical Deductible		Integrated with Medical Deductible		$200 brand deductible	
PRESCRIPTION DRUGS						
ROUTINE PREVENTATIVE	100%; deductible waived		Covered in Full		Covered in Full	
GENERICS	Plan pays 80%*	Member pays additional 20% of the allowable amount plus coinsurance	$15 copay		$15 copay	
BRAND NAME	Plan pays 75%*		30%*		25%*	
NON-PREFERRED BRAND NAME	Plan pays 50%*		50%*		50%*	
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	
MAIL ORDER PRESCRIPTION DRUGS (90-DAY SUPPLY)						
ROUTINE PREVENTATIVE	100%; deductible waived	Not applicable	Covered in Full		Covered in Full	
GENERIC	Plan pays 80%*	Member pays additional 20% of the allowable amount plus coinsurance	$45 copay		$45 copay	
BRAND NAME	Plan pays 75%*		30%*		25%*	
NON-PREFERRED BRAND NAME	Plan pays 50%*		50%*		50%*	
SPECIALTY (31-DAY SUPPLY)	Plan pays 80%*	Not covered	$0 if Flex Access eligible; 30%*		$0 if Flex Access eligible; 30%*	

*After deductible

Health Plan Highlights is for September 1, 2024 – August 31, 2025 Plan Year.