Premium and Benefit Comparison - Medical/Rx
Prepared for: Holton Public Schools
Effective Date: January 1, 2026

Williams & Company, LLC. EMPLOYEE BENEFITS

Medical Plan		MESSA	MESSA	Priority Health	Priority Health	Blue Care Network	Blue Care Network	Health Alliance Plan
Plan Type		ABC Plan 2 (DG)	ABC Plan 2 (DK)	HSA PPO	HSA PPO	HSA HMO	HSA HMO	
In Network Deductible		$2,000/$4,000	$2,000/$4,000	$2,000 / $4,000	$2,000 / $4,000	$2,000 / $4,000	$2,000 / $4,000	
In Network Coinsurance		0%	10%	0%	10%	0%	10%	DECLINED TO QUOTE
In Network Coinsurance Max		n/a	n/a	n/a	n/a	n/a	n/a	
In Network Out-Pocket Max		$4,000/$8,000	$5,000/$8,500	$4,000 / $8,000	$4,000 / $8,000	$4,000 / $8,000	$4,000 / $8,000	
Out of Network Deductible		undefined	undefined	$4,000 / $8,000	$4,000 / $8,000	n/a	n/a	
Out Network Coinsurance		undefined	undefined	20%	30%	n/a	n/a	
Out Network Coinsurance Max		undefined	undefined	n/a	n/a	n/a	n/a	
In Network Out-Pocket Max		undefined	undefined	$8,000 / $16,000	$8,000 / $16,000	n/a	n/a	
		In-Network Benefits	In-Network Benefits	In-Network Benefits	In-Network Benefits	In-Network Benefits	In-Network Benefits	In-Network Benefits
Office Visit-PCP		100% after deductible	90% after deductible	100% after deductible	90% after deductible	100% after deductible	90% after deductible	
Office Visit- Specialist		100% after deductible	90% after deductible	100% after deductible	90% after deductible	100% after deductible	90% after deductible	
Urgent Care		100% after deductible	90% after deductible	100% after deductible	90% after deductible	100% after deductible	90% after deductible	
Emergency Room		100% after deductible	90% after deductible	100% after deductible	90% after deductible	100% after deductible	90% after deductible	
Ambulance		100% after deductible	90% after deductible	100% after deductible	90% after deductible	100% after deductible	90% after deductible	
Hospital		100% after deductible	90% after deductible	100% after deductible	90% after deductible	100% after deductible	90% after deductible	
Chiropractic Care - Non-acute		100% after deductible, up to 36 visits/yr	90% after deductible, up to 36 visits/yr	100% after deductible, up to 30 visits/yr	90% after deductible, up to 30 visits/yr	100% after deductible, up to 30 visits/yr	90% after deductible, up to 30 visits/yr	
DME/P&O		100% after deductible	90% after deductible	100% after deductible	90% after deductible	50% after deductible	50% after deductible	
Rx Copay - Tier-1 Pref. Generic						$20 copay	$20 copay	
Rx Copay - Tier-2 Non-Pref. Generic		$10 copay	$10 copay	$10 copay	$10 copay	$30 copay	$30 copay	
Rx Copay - Tier-3 Pref. Brand		20% coinsurance $40 min. - $80 max.	20% coinsurance $40 min. - $80 max.	$40 copay	$40 copay	$60 copay	$60 copay	
Rx Copay - Tier-4 Non-Pref. Brand		20% coinsurance $60 min. - $100 max.	20% coinsurance $60 min. - $100 max.	$80 copay	$80 copay	$80 copay	$80 copay	
Rx Copay - Tier 5 Pref. Specialty		see Generic or Brand copay	see Generic or Brand copay	20% copay up to $100	20% copay up to $100	20% copay up to $200	20% copay up to $200	
Rx Copay - Tier 6 Non-Pref. Specialty		see Generic or Brand copay	see Generic or Brand copay	20% copay up to $200	20% copay up to $200	20% copay up to $300	20% copay up to $300	
Rx 90-day supply		3 months / 2.5x copay	3 months / 2.5x copay	tiers 1-4 90-days for 2 copays	tiers 1-4 90-days for 2 copays	3 months / 2 copays	3 months / 2 copays	
Fixed Costs	Census	2026	2026	2026	2026	2026	2026	2026
Single	21	$984.26	$912.61	$933.26	$633.15	$802.31	$748.90	
Double	7	$2,214.59	$2,053.37	$2,053.36	$1,393.05	$1,925.54	$1,797.36	
Family	19	$2,755.93	$2,555.31	$2,706.82	$1,836.39	$2,406.92	$2,246.70	
Projected Annual Premium		$1,062,411.12	$985,071.48	$1,024,818.72	$695,266.92	$912,705.24	$851,948.64	$0.00

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.

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Item	MESSA	UNUM	Companion Life	Pacific Life	Kansas City Life
	Delta Dental	Elite Plan (Passive PPO)	Dental by Design	Select Dental	
Deductible	None	$50 (family max 3x)	$50 (family max 3x)	$50 (family max 3x)	$50 (family max 3x)
Deductible apply to Class I?	N/A	No	No	No	No
Diagnostic & Preventive Services	80%	80%	80%	80%	80%
Basic Services	80%	80%	80%	80%	80%
Major Restorative Services	80%	50%	80%	80%	80%
Annual Max Benefit (per person)	UCR	$1,000	$1,000	$1,000	$1,000
Orthodontics	80%	50%	80%	60%	80%
Orthodontia Max Benefit (per lifetime)	UCR	$1,000	$1,000	$1,000	$1,000

Rates Effective	1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026
Employee		$37.20	$33.23	$35.12	$35.09
Employee + 1	Aggregate Rates	$73.69	$64.16	$67.84	$66.63
Employee & Child(ren)	Not Provided	$96.65			
Family		$145.62	$129.98	$137.12	$143.39

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Item	MESSA	Pacific Life	Kansas City Life	UNUM	Companion Life
	VSP 2	EyeMed Classic-12	VSP	EyeMed	VSP Choice Plan
Exam	12 months	12 months	12 months	12 months	12 months
Lenses	12 months	12 months	12 months	12 months	12 months
Frames	12 months	12 months	12 months	12 months	12 months
	In Network	**In Network**	**In Network**	**In Network**	**In Network**
Exam	$6.50 copay	$10 copay	$10 copay	$10 copay	$10 copay
Prescription Eyeglasses			$25 copay		$25 copay
Materials					
Single vision lenses	$18 copay	$25 copay	Included in prescription eyeglass copay	$25 copay	Included in prescription eyeglass copay
Bifocal lenses	$18 copay	$25 copay		$25 copay	
Trifocal lenses	$18 copay	$25 copay		$25 copay	
Lenticular lenses	$18 copay	$25 copay		$25 copay	
Progressive Lenses	$18 copay				
Standard Progressives	discounts available at	$90 copay		$90 copay	
Premium Progressives	in-network providers	$110-$135 copays		$110-$135 copays	
Frames	covered up to $65 retail allowance, 20% off balance over $65.	$130 retail allowance	$130 retail allowance included in prescription eyeglass copay	$130 retail allowance	$130 retail allowance included in prescription eyeglass copay
Contact Lenses	covered up to $90 retail allowance, 15% discount (conventional) or 10% discount (disposable) off balance over $90. Medically necessary $0 copay.	$40 fee for contact lens exam (fitting and evaluation) and $130 allowance for the contact lenses. Medically necessary contact lenses covered.	$60 allowance applied to contact lens exam (fitting and evaluation) and $130 allowance for the contact lenses. Medically necessary contact lenses covered in full with prescription eyeglass copay.	$40 fee for contact lens exam (fitting and evaluation) and $130 allowance for the contact lenses. Medically necessary contact lenses covered.	$60 allowance applied to contact lens exam (fitting and evaluation) and $130 allowance for the contact lenses. Medically necessary contact lenses covered in full with prescription eyeglass copay.
Rates Effective	1/1/2026	1/1/2026	1/1/2026	1/1/2026	1/1/2026
EE		$5.38	$6.36	$4.84	$6.06
EE+1	Aggregate Rates	$11.52	$12.73	$9.68	$11.04
EE+Child(ren)	Not Provided		$0.00	$10.79	$11.74
FAM		$17.36	$20.49	$16.87	$18.12

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