CERTIFICATED (MTA/CTA)
MONTHLY PREMIUMS (REQ'D. 50%+FTE *****)
Effective January 1, 2024

A	B	C	D	E (C minus D = E)	F
PLAN TYPES	NO. COVERED	MONTHLY PREMIUMS	EMPLOYER MONTHLY CONTRIBUTION *****	EMPLOYEE MONTHLY CONTRIBUTION *****	GROUP #
UNITED HEALTHCARE (UHC), SIGNATURE VALUE, TRADITIONAL HMO HIGH PLAN - FULL NETWORK					
Office visit co-pay: $30; Inpatient Hospital: $750; $0 Deductible; OOP Maximum $1,500/$3,000	Employee Only	1,374.18	1,271.00	103.18	HMO HIGH PLAN MTA CERT #252199 CSEA #252198 MGMT #252202
Rx Co-pay: Generic: $10	Employee+1	2,748.35	1,271.00	1,477.35	
Rx Co-pay: Formulary Brand: $25; Non-Formulary Brand:$40	Family (3+members)	3,888.92	1,271.00	2,617.92	
UNITED HEALTHCARE (UHC), SIGNATURE VALUE, HMO MID PLAN - FULL NETWORK					
Office visit co-pay: $30 (ded waived); Inpatient Hospital Co-insurance: 10% (after deductible)	Employee Only	1,207.36	1,207.36	-	DHMO MID PLAN MTA CERT #252211 CSEA #252210 MGMT #252212
Annual Deductible: $250/$500 (Ind/Fam); OOP Maximum: $2500/$5000 (Ind/Fam)	Employee+1	2,414.72	1,271.00	1,143.72	
Rx Co-pay: Generic: $10; Formulary Brand: $30, Non-formulary Brand: $50	Family (3+members)	3,416.84	1,271.00	2,145.84	
UNITED HEALTHCARE (UHC), SIGNATURE VALUE, HMO LOW PLAN - FULL NETWORK					
Office visit co-pay: $40 (ded waived); Inpatient Hospital Co-insurance: 30% (after deductible)	Employee Only	1,140.15	1,140.15	-	DHMO LOW PLAN MTA CERT #252221 CSEA #252220 MGMT #252222
Annual Deductible: $500/$1000 (Ind/Fam); OOP Maximum: $5000/$10000 (Ind/Fam)	Employee+1	2,280.30	1,271.00	1,009.30	
Rx Co-pay: Generic: $10; Formulary Brand: $30; Non-Formulary Brand: $50	Family (3+members)	3,226.61	1,271.00	1,955.61	
UNITED HEALTH CARE (UHC), SIGNATURE VALUE HARMONY, TRADITIONAL HMO HIGH PLAN - LIMITED NETWORK					
Office visit co-pay: $30; Inpatient Hospital: $750; $0 Deductible; OOP Maximum $1,500/$3,000	Employee Only	957.54	957.54	-	HMO HIGH PLAN MTA CERT #252192 CSEA #2522191 MGMT #2522195
Rx Co-pay: Generic: $10	Employee+1	1,915.07	1,271.00	644.07	
Rx Co-pay: Formulary Brand: $25; Non-Formulary Brand:$40	Family (3+members)	2,709.81	1,271.00	1,438.81	
UNITED HEALTHCARE (UHC), SIGNATURE VALUE HARMONY, HMO MID PLAN - LIMITED NETWORK					
Office visit co-pay: $30 (ded waived); Inpatient Hospital Co-insurance: 10% (after deductible)	Employee Only	836.18	836.18	-	DHMO MID PLAN MTA CERT #252206 CSEA #252205 MGMT #252207
Annual Deductible: $250/$500 (Ind/Fam); OOP Maximum: $2500/$5000 (Ind/Fam)	Employee+1	1,672.36	1,271.00	401.36	
Rx Co-pay: Generic: $10; Formulary Brand: $30, Non-formulary Brand: $50	Family (3+members)	2,366.39	1,271.00	1,095.39	
UNITED HEALTHCARE (UHC), SIGNATURE VALUE HARMONY, HMO LOW PLAN - LIMITED NETWORK					
Office visit co-pay: $40 (ded waived); Inpatient Hospital Co-insurance: 30% (after deductible)	Employee Only	789.07	789.07	-	DHMO LOW PLAN MTA CERT #252216 CSEA #252215 MGMT #252217
Annual Deductible: $500/$1000 (Ind/Fam); OOP Maximum: $5000/$10000 (Ind/Fam)	Employee+1	1,578.14	1,271.00	307.14	
Rx Co-pay: Generic: $10; Formulary Brand: $30; Non-Formulary Brand: $50	Family (3+members)	2,233.06	1,271.00	962.06	
PPO UNITED HEALTHCARE (UHC) MODIFIED HSA, SELECT PLUS, WITH OPTIONAL HEALTH SAVINGS ACCOUNT (HSA) DEDUCTIBLE PLAN					
Office visit co-pay: $0 after ded	Employee Only	1,648.00	1,271.00	377.00	PPO DEDUCTIBLE MTA CERT/CSEA/MGMT #918667 HSA#918667SIG
In-network Annual Deductible: $2800/$5600 (Ind/Fam); OOP Maximum: $2800/$5600 (Ind/Fam)	Employee+1	3,460.81	1,271.00	2,189.81	
In-network Rx Co-pay: Generic: $10 after ded; Formulary Brand: $30 after ded; Non-Formulary Brand: $50 after ded	Family (3+members)	4,976.95	1,271.00	3,705.95	
KAISER PERMANENTE TRADITIONAL HMO HIGH, CO-PAYMENT					
Office visit: $20; OOP Maximum: $1500/3000	Employee Only	925.45	925.45	-	HMO HIGH PLAN CERT 038160-0210 CLASS 038160-0510 MGMT 038160-0110
Inpatient Hospital: $500; Chiropractic co-pay:$10 (ded waived) limited to 20 visits per calendar year	Employee+1	1,850.90	1,271.00	579.90	
Rx Co-pay: Generic $10 Brand Formulary: $25	Family (3+members)	2,619.02	1,271.00	1,348.02	
KAISER PERMANENTE HMO MID DEDUCTIBLE PLAN, 90%/10% COINSURANCE					
Office visit: $20; Annual Deductible: $500/$1000; OOP Maximum: $3000/$6000; Co-insurance: 10%	Employee Only	881.82	881.82	-	DHMO - MID PLAN CERT 038160-0232 CLASS 038160-0233 MGMT 038160-0230
Rx Co-pay: Generic: $10; Chiropractic co-pay:$10 (ded waived) limited to 20 visits per calendar year	Employee+1	1,763.64	1,271.00	492.64	
Rx Co-pay: Brand Formulary: $30	Family (3+members)	2,495.55	1,271.00	1,224.55	
KAISER PERMANENTE HMO LOW DEDUCTIBLE PLAN, 70%/30% COINSURANCE					
Office visit:$40; Annual Deductible: $3000/$6000; OOP Maximum: $6000/$12000; Co-insurance: 30%	Employee Only	742.14	742.14	-	DHMO - LOW PLAN CERT 038160-0331 CLASS 038160-0332 MGMT 038160-0330 ACA- 038160-0333
Rx Co-pay: Generic: $10; Chiropractic co-pay:$10 (ded waived) limited to 20 visits per calendar year	Employee+1	1,484.26	1,271.00	213.26	
Rx Co-pay: Brand Formulary: $30	Family (3+members)	2,100.23	1,271.00	829.23	
DELTA DENTAL PPO PREMIUM PLAN					
Annual Maximum Allowance: $3,200 (in-network) / $3,000 (out-of-network)	Employee Only	67.63	67.63	-	07102-11190
Cleanings: 3 per year; Implants: 50%	Employee+1	135.26	135.26	-	
Child/Adult Ortho: 100%, $3000 maximum	Family (3+members)	228.66	228.66	-	
DENTAL INDEMNITY PLAN					
No "incentive" feature- Any licensed dentist	Employee Only	71.01	71.01	-	
Annual Maximum Allowance: $2,500: Cleanings: 2 per year: Implants 50%	Employee+1	142.02	142.02	-	
Child/Adult Ortho: 100%, $2,000 Maximums	Family (3+members)	240.09	240.09	-	
VISION SERVICE (VSP) HIGH PLAN					
Co-pay: $15 every 12 months Exam (in-network), up to $45 (out-of-network)	Employee Only	8.45	8.45	-	3106124A
Frames: Every 24 months; co-pay combined with exam, up to $130 allowance; 20% discount over the allowed amou	Employee+1	16.89	16.89	-	
Lenses: Every 12 months; Contact Lenses: $0 co-pay, up to $130 allowance/ up to $105 (out-of-network)	Family (3+members)	31.89	31.89	-	

***** Employees with monthly premium contributions will have summer share contributions. These contributions apply towards the summer months' benefits when you don't earn normal paychecks (June to July and/or June to August). Summer Share is for less than (<) 12 month employees (11, 10.5, and 9.5 month).*****

***** District's and part-time permanent employees' monthly premium contributions are pro-rated based on part-time FTE. *****

Matrix Rate sheets and explanation of Benefits and Summaries are available at MUSD Payroll and Benefits website: https://www.musd.org/payroll-and-benefits.html and at https://www.workterra.net (Forms and Library)

Employees who waive MUSD benefits must provide proof of coverage.

Per carriers' agreement: If you waive MUSD medical benefits within 30 days of your eligibility, you must wait during Open Enrollment month that same year you were hired to enroll OR within 30 days of a qualifying event.
Per carriers' and SCCSIG's agreement: If you waive MUSD dental and vision benefits within 30 days of your eligibility, you must wait during Open Enrollment month that same year you were hired to enroll, within 30 days of a qualifying event, and/or 3 years after your initial eligibility. Dental and Vision plans Open Enrollment plan is every 3 years, unless you have a 30 day qualifying event.
Per carriers' requirements: If adding family members onto MUSD benefits, you must complete the audit and provide legal documents (marriage certificated, Declaration of Domestic Partnership, birth certificates, court documents for legal adoption, etc.). Without documents, family members will not be enrolled onto the plans.

As an employee of MUSD, you are responsible in understanding your benefits prior to obtaining health, dental, and vision services.

Contact Payroll@musd.org if you have any questions.