Open Enrollment 2027: Frequently Asked Questions

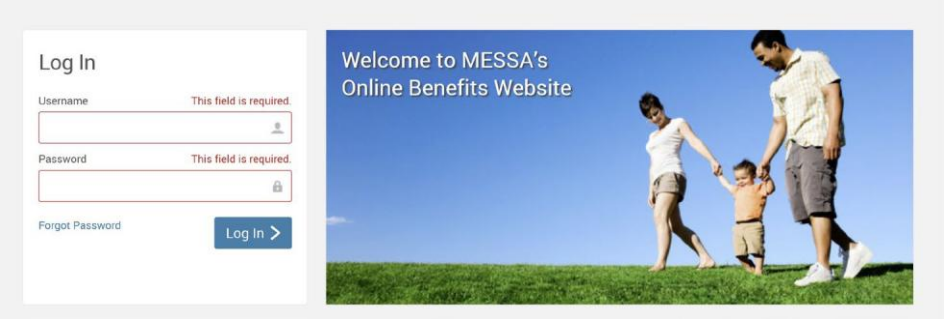
How do I access the enrollment site?

Check on Infohost for the Open Enrollment links and watch your email and the district portal for these reminders — they will be sent multiple times during the enrollment window.

- **For GRPSPA, Exempt and Support Non-Exempt Employees:**

  Visit: MESSA BSWIFT

  - **Username:** GRPS Outlook emailaddress
  - **Password:** Last 4 of your SSN

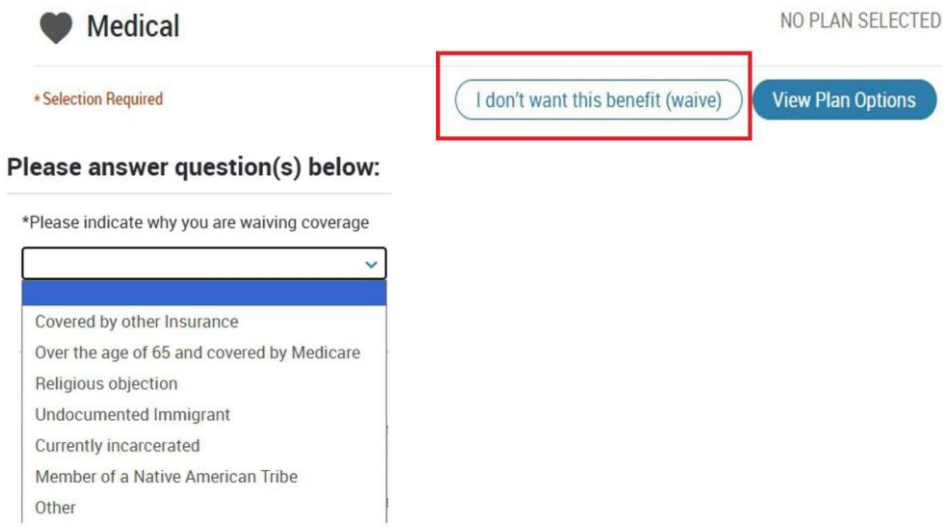


Be sure to save your enrollment confirmation for your records.

If you need additional assistance, please call The Pool Member Services at (877) 752.1233

How do I waive health insurance and sign up for cash in lieu?

Log into your MESSA account and select 'I don't want this benefit(waive)':



Note: You must upload proof of your health insurance coverage, e.g. copy of your health insurance card or a screenshot of an enrollment website showing you are covered, to the MESSA enrollment site before completing your enrollment.

What's the difference between a copay and coinsurance?

A copay is a flat dollar amount (like $30 for an office visit), while coinsurance is a percentage of the cost that you and the plan split (like 80/20) after you've met your deductible.

Does preventive care count toward my deductible?

No. In-network preventive care (like an annual physical or standard immunizations) is typically covered at 100% and does not require you to meet your deductible first. Diagnostic or treatment-related care generally does apply toward your deductible and coinsurance.

What happens once I hit my out-of-pocket maximum?

Once your total out-of-pocket spending (deductible, copays, and coinsurance combined) reaches your plan's out-of-pocket maximum for the year, the plan pays 100% of covered, in-network costs for the remainder of the plan year.

Why does staying in-network matter?

In-network providers have agreed to discounted rates with the insurance company, which generally means lower costs for you. Going out-of-network can mean higher costs, a separate (often higher) deductible, or no coverage at all, depending on your plan.

What if I have a life change after Open Enrollment ends?

Outside of Open Enrollment, you can only change your elections if you experience a Qualifying Life Event (such as marriage, birth or adoption of a child, divorce, or loss of other coverage). You typically have a limited window (30 days) from the qualifying event date to make a change, so be sure to login to MESSA.org or MESSA/bswift.org and choose a special enrollment. Be sure you have the necessary documentation to upload to support your life change, e.g. marriage certificate, birth certificates, etc.

Where can I get help understanding my options?

We've created a document called Employee Benefits – Choosing the Right Health Care Plan for You and Your Family (See Infohost) to help you make the best choice for your situation. There are also plan comparison grids online and within your group's Benefit Guide showing you how the plan offerings compare. You can also reach out to the Benefits team with your specific questions — we're happy to answer your questions.

Can the Benefits staff tell me which plan to pick?

We are not permitted to recommend or select a specific plan on your behalf — this is a legal requirement, not a matter of preference. Remember: we are a tool to educate, and the final decision on which plan best fits your needs is yours to make.

Key Insurance Terms to Know

Use this table as a quick reference while you compare plans. Terms are listed in a logical order — from what you pay each pay period, to what you pay for care, to how the plan protects you once you've paid a lot.

Term	What It Means	Example
Premium	The amount deducted from your paycheck to have health coverage. You pay this whether or not you use medical care.	*Your per-pay-period contribution for the plan you choose.*
Deductible	The amount you pay out of pocket for covered services before your insurance starts to pay its share.	*A $1,500 deductible means you pay the first $1,500 of covered care yourself.*
Copay (Copayment)	A fixed dollar amount you pay for a covered service at the time you receive it.	*A $30 copay for a primary care office visit.*
Coinsurance	After you meet your deductible, the percentage of costs you and the plan each pay for covered services.	*80/20 coinsurance means the plan pays 80% and you pay 20% after the deductible.*
In-Network	Doctors, hospitals, and providers that have a contract with your insurance company to provide services at a discounted rate.	*Using an in-network doctor generally costs you less than an out-of-network one.*
Out-of-Network	Providers who do not have a contract with your plan. Services often cost more and may not be covered at all.	*An out-of-network specialist may bill you the full, undiscounted rate.*
Contribution	The portion of the monthly premium cost that GRPS (the District) pays on your behalf toward your coverage.	*GRPS may contribute a set amount per pay period toward your medical plan.*
Out-of-Pocket Maximum	The most you will have to pay for covered services in a plan year. Once you reach it, the plan pays 100% of covered costs.	*If your out-of-pocket max is $4,000 and you reach it in October, covered care is fully paid the rest of the year.*
Preventive Care	Routine care meant to prevent illness or catch problems early, typically covered at 100% with no cost to you when in-network.	*Annual physicals, immunizations, and routine screenings.*
Diagnostic Care	Care used to investigate or diagnose a specific symptom, concern, or condition. This is different from preventive care and usually applies to your deductible/coinsurance.	*A mammogram ordered because you reported a symptom (rather than a routine screening).*
Explanation of Benefits (EOB)	A statement from your insurance company showing what was billed, what the plan paid, and what you may owe. It is not a bill.	*You'll receive an EOB after a doctor's visit or procedure.*

Term	What It Means	Example
Formulary	The list of prescription drugs covered by your health plan, often organized into cost tiers.	*A generic drug may be Tier 1 (lowest cost); a brand-name drug may be Tier 2 or 3.*
HSA (Health Savings Account)	A tax-advantaged savings account available with certain high-deductible health plans, used to pay for qualified medical expenses.	*Funds roll over year to year and belong to you even if you change jobs.*
FSA (Flexible Spending Account)	A tax-advantaged account for setting aside pre-tax dollars for eligible medical or dependent care expenses, usually with a use-it-or-lose-it rule.	*Setting aside pre-tax pay for predictable expenses like contacts or copays.*
Open Enrollment	The annual period when you can enroll in, change, or drop your benefit elections for the upcoming plan year.	*Elections made during Open Enrollment generally cannot be changed until the next Open Enrollment or a qualifying life event.*
Qualifying Life Event (QLE)	A major life change (marriage, birth of a child, loss of other coverage, etc.) that allows you to change your benefits outside of Open Enrollment.	*Having a baby allows you to add the child to your plan mid-year.*