

# MESSA Choices

## Medical plan highlights



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**Effective Date: 1/1/2025**

**MESSA Account: Yale Public Schools**

**Employee Group:**

**In-network health care benefits for you and your covered dependents**

All services must be **medically necessary** and performed by a payable provider.

This is a brief summary of in-network benefits. If you obtain medical services from an out-of-network provider without a referral from an in-network provider, you may have to pay 100% of the cost or the applicable out-of-network cost share amounts. For coverage details, go to [messa.org](http://messa.org) to log in to your MyMESSA account or call the MESSA Member Service Center at 800-336-0013 or TTY 888-445-5614.

Plan features	In-network
<p><b>Annual deductible</b>                      The amount you pay for health care services before your health insurance begins to pay. If one member of the family meets the individual deductible, but the family deductible has not been met, MESSA will pay for covered services for that member only. Covered services for the remaining family members will be paid when the family deductible has been met. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31.</p>	<p>\$500 individual/\$1,000 family</p>
<p><b>Medical copayment</b>                      A fixed amount you pay for a medical visit.</p>	<p>\$10 Teladoc Health 24/7 care for minor illnesses, injuries and mental health, \$10 Teladoc virtual primary care visit, \$10 office visit for medical, mental health and/or substance use disorder treatment, \$10 specialist visit, \$25 urgent care, \$50 emergency room, if not admitted</p>
<p><b>Medical coinsurance</b>                      A fixed percentage you pay for a medical service.</p>	<p>0%</p>
<p><b>Prescription drug coverage</b>                      Subject to prescription copayments and coinsurance.</p>	<p>Saver Rx</p>
<p><b>Annual out-of-pocket maximums</b>                      The most you have to pay for covered medical services in a calendar year, including deductible, applicable coinsurance and copayments. Charges above approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximums.  <b>Prescription:</b> The most you have to pay for prescription copayments and coinsurance in a calendar year.</p>	<p>Medical: \$1,500 individual/\$3,000 family                      Prescription: \$1,000 individual/\$2,000 family</p>
<p><b>In-network preventive care – no cost to you</b></p>	
<p><b>Preventive care</b>                      Certain services such as annual exams, screenings, childhood and adult immunizations, and certain preventive medications.</p>	<p><b>Prenatal and postnatal care</b>                      Prenatal and postnatal doctor visits.</p>
<p><b>In-network services subject to deductible and applicable copayment</b></p>	
<p><b>Emergency room (ER)</b>                      Copayment waived if admitted or due to an accidental injury.</p>	<p><b>Mental health and substance use disorder - outpatient care</b></p>
<p><b>Office visit</b>                      e.g. primary care physician, obstetrics and gynecology and pediatric visits.</p>	<p><b>Specialist visit</b></p>

<b>Teladoc Health visits</b> 24/7 care for minor illnesses, injuries and mental health; virtual primary care visits.	<b>Urgent care</b> Copayment waived if services are required to treat a medical emergency or accidental injury.
<b>In-network services subject to deductible and applicable coinsurance</b>	
<b>Acupuncture</b> Must be performed by an M.D. or D.O or a registered acupuncturist.	<b>Allergy testing and therapy</b> Subject to deductible and coinsurance. Office visit copayment may apply
<b>Ambulance</b>	<b>Autism - applied behavior analysis (ABA) services</b>
<b>Bariatric surgery</b>	<b>Chiropractic services including modalities</b> Up to 38 visits per calendar year.
<b>Diagnostic lab and X-ray</b>	<b>Durable medical equipment (DME)</b>
<b>Hearing aids</b> There is a maximum benefit for a hearing aid for each ear during a 36-month period.	<b>Hearing care</b> Hearing related services performed by an M.D. or D.O.
<b>Home health care</b>	<b>Human organ transplant</b> Must be performed at an approved facility.
<b>Inpatient hospital</b>	<b>Medical supplies</b>
<b>Mental health and substance use disorder - inpatient care</b>	<b>Osteopathic manipulations</b> Performed by an Osteopathic physician. Up to 38 visits per
<b>Outpatient physical, occupational and speech therapy</b> Up to a combined benefit max of 60 visits per individual per calendar year.	<b>Prosthetics and orthotics</b>
<b>Radiation and chemotherapy</b>	<b>Skilled nursing facility</b> Up to a max of 120 days per calendar year.
<b>Home delivery of prescription medications</b>	
MESSA members can save time and money by ordering prescription medications through the Optum Rx mail order pharmacy. If your coverage includes a mandatory mail prescription rider, you must obtain most long-term maintenance medications from Optum Rx. For more information, go to <a href="http://messa.org">messa.org</a> to log in to your MyMESSA account and link to the Optum Rx website. For general questions about your prescription coverage, call MESSA at 800-336-0013 or TTY 888-445-5614. For questions about a prescription order, call Optum Rx at 800-903-8346.	
<b>Medical care outside the U.S.</b>	
MESSA members have access to doctors and hospitals with the BCBS Global Core program. You may want to visit the BCBS Global Core program's website ( <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a> ) to find in-network providers prior to your departure.	
<b>Covered services and approved amounts</b>	
<b>In-network providers</b> bill BCBSM directly. Payments for covered services are based on BCBSM's approved amounts. Your liability is limited to the plan deductible, copayment and coinsurance requirements.	
<b>Out-of-network providers</b> may or may not bill BCBSM directly. The member is responsible to the provider for any deductibles, copayments, coinsurance and amounts that are in excess of the approved amount for the services as predetermined by MESSA and BCBSM. These amounts may be substantial.	
<i>Medical benefits underwritten by Blue Cross Blue Shield of Michigan (BCBSM) &amp; 4 Ever Life Insurance Company. BCBSM is an independent licensee of the Blue Cross and Blue Shield Association.</i>	
<b>Life and accidental death &amp; dismemberment insurance</b>	
<b>Life insurance:</b> \$5,000 policy for you.	
<b>Accidental death &amp; dismemberment insurance (AD&amp;D):</b> \$5,000 policy for you.	
<i>Life and AD&amp;D insurance underwritten by Life Insurance Company of North America.</i>	

If you have  
**MESSA Saver Rx**  
 with **Mandatory Mail**:

# MESSA Saver Rx

## Overview



You must order all 90-day prescriptions and certain long-term maintenance medications through Optum Rx for home delivery.

To order medications through Optum Rx, log in to your MyMESSA account at [messa.org](http://messa.org) and select "Optum Rx home delivery." You may also call MESSA at 800-336-0013 or TTY: 888-445-5614 for assistance or contact us via live chat from your MyMESSA account or through the MESSA app.

- A prescription is required for each covered drug, including covered over-the-counter medications.
- You are responsible for prescription copayments until your prescription out-of-pocket maximum is reached.
- Save money by using Optum Rx for home delivery of your medications.
- In most cases, if your doctor writes "Dispense as written" or "DAW," your cost will be higher.
- If the approved amount is less than the copayment, you pay only the approved amount for the drug.
- Specialty medications are handled separately. Specialty drugs must be obtained by mail through Walgreens Specialty Pharmacy or select Walgreens retail pharmacies. If you obtain them from any other provider, you may be responsible for the total cost.
- The initial quantity of select specialty drugs may be limited, and your cost will be reduced accordingly. Additional fills for specialty drugs are limited to a 30-day supply.
- Your prescription plan includes a number of money-saving features, including prior authorization, step therapy and quantity limits.

Copayment one-month supply	Prescription drug
No cost to you	— Specific preventive medications mandated by federal law are covered 100% with no deductible required. Age and gender limits apply.
\$2	— Specific generic drugs used to treat asthma, diabetes, high blood pressure, high cholesterol and coronary artery disease.
\$10	— All other generic drugs. — Specific over-the-counter medications with a written prescription for the treatment of seasonal allergies and heartburn. Cannot combine with a coupon or other manufacturer offer.
\$20	— Specific brand-name maintenance drugs used to treat asthma and diabetes for which there is no generic equivalent.
\$40	— All other brand-name drugs, including single-source drugs where no generic is available. — You will be responsible for the cost difference between the approved amount and the actual retail cost of the drug when you insist on a brand-name but a generic is available and medically appropriate.

**For specific drugs under each category, go to [messa.org](http://messa.org) or call the MESSA Member Service Center at 800-336-0013 or TTY: 888-445-5614 or contact us via live chat from your MyMESSA account or through the MESSA app.**

**Up to a 90-day supply of insulin may be obtained for the same amount as a 34-day supply from an in-network provider.**

