Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

MESSA ABC & 3-Tier RX

Plan 2

MESSA

Coverage for: Individual/Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.messa.org or call MESSA at 1-800-336-0013. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call MESSA at 1-800-336-0013 to request a copy.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$2,000 Individual/ $4,000 Family	$4,000 Individual/ $8,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at (https://www.healthcare.gov/coverage/preventive-care-benefits/).
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)	$4,000 Individual/ $8,000 Family	$8,000 Individual/ $16,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of network providers see (http://www.messa.org) or call MESSA at 800-336-0013		This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.		You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	20% coinsurance	Members 18 years and older have access to Virtual Primary Care visits by a BCBSM selected vendor.
	Specialist visit	No Charge	20% coinsurance	None
	Preventive care/ screening/ immunization	No Charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance	May require prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.messa.org	Generic drugs	$10 copay/prescription for retail 34-day supply; $25 copay/prescription for retail or mail order 90-day supply	In-Network copay plus an additional 25% of the approved amount	Prior authorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. Mail order drugs are not covered out-of-network
	Preferred brand-name drugs	20% coinsurance of the approved amount, but not less than $40 copay/prescription or more than $80 copay/prescription for retail 34-day supply; 20% coinsurance of the approved amount, but not less than $100 copay/prescription or more than $200 copay/prescription for retail or mail order 90-day supply	In-Network copay plus an additional 25% of the approved amount	
	Non-preferred brand-name drugs	20% coinsurance of the approved amount, but not less than $60 copay/prescription or more than $100 copay/prescription for retail 34-day supply; 20% coinsurance of the approved amount, but not less than $150 copay/prescription or more than $250 copay/prescription for retail or mail order 90-day supply	In-Network copay plus an additional 25% of the approved amount	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% coinsurance	None
	Physician/surgeon fees	No Charge	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	No Charge	No Charge	None
	Emergency medical transportation	No Charge	No Charge	Mileage limits apply
	Urgent care	No Charge	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% coinsurance	Prior authorization is required.
	Physician/surgeon fee	No Charge	20% coinsurance	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	No Charge	20% coinsurance	None
	Inpatient services	No Charge	20% coinsurance	Prior authorization is required.
If you are pregnant	Office visits	No Charge; deductible does not apply	20% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services cost share may apply. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No Charge	20% coinsurance	None
	Childbirth/delivery facility services	No Charge	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Physician certification required.
	Rehabilitation services	No Charge	20% coinsurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	No Charge for Applied Behavior Analysis; No Charge for Physical, Speech and Occupational Therapy	20% coinsurance	Prior authorization is required for applied behavior analysis (ABA). Services rendered by an approved licensed behavior analyst (LBA) will apply the In-network cost-sharing.
	Skilled nursing care	No Charge	No Charge	Physician certification required. Limited to 120 days per member per calendar year
	Durable medical equipment	No Charge	No Charge	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge	No Charge	Physician certification required. Unlimited visits.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental care (Adult)
- Long term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture treatment
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See (http://www.messa.org)
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling 1-800-324-6172. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact MESSA by calling 1-800-336-0013.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or http://www.michigan.gov/difs or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: **See Addendum**

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,070**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$90
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,510**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies)*
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or coinsurance, or benefits not otherwise covered.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Language services

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call MESSA's Member Service Center at 800.336.0013 or TTY 888.445.5614.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de servicios para miembros de MESSA, que aparece en la parte trasera de su tarjeta.

إذا كنت أنت أو شخص آخر تساعده بحاجة إلى المساندة، فمن حقّك الحصول على المساعدة والمعلومات بلغتك بدون أيّ كلفة. للتحدّث إلى مترجم، اتّصل بالرقم المخصّص لخدمات أعضاء MESSA الموجود على ظهر بطاقتك.

如果您，或是您正在協助的對象，需要協助，您有權利免費已您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的MESSA會員服務電話。

Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ, cần sự giúp đỡ, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, hãy gọi đến số dịch vụ thành viên MESSA trên mặt sau của thẻ.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e shërbimit të anëtarësimit MESSA në anën e pasme të kartës tuaj.

귀하 또는 귀하가 도움을 제공하는 누군가가 도움이 필요한 경우, 귀하는 귀하의 모국어로 무료로 도움과 정보를 제공 받을 권리를 갖고 있습니다. 통역사의 도움을 받으려면 카드 뒷면의 MESSA 회원 서비스 번호로 전화하십시오.

[illegible] MESSA [illegible]

যদি আপনার বা আপদন সাহাযয কররন এমন কাররা সহাযতার প্ররযাজন হয, তাহরে ককারনা খরচ ছাড়াই আপনার ভাষায় সহাযতা ও তথ্য পাওযার অদিকার ররযরছ। ককারনা কিাভাষীর সারথ্ কথ্া বেরত, আপনার কারডের কপছরন প্রিত MESSA সিসয পদররষবার নম্বরর কে করুন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi członków MESSA wskazany na odwrocie Twojej karty.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigen, haben Sie das Recht kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer der MESSA-Mitgliederbetreuung auf der Rückseite Ihrer Karte an. Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere gratuitamente aiuto e informazioni nella tua lingua. Per parlare con un interprete, chiama il numero del servizio membri MESSA presente sul retro della tua tessera.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたMESSAメンバーサービスの電話番号までお電話ください。

Если Вам или лицу, которому Вы помогаете, нужна помощь, то Вы имеете право на бесплатное получение помощи и информации на Вашем языке. Для разговора с переводчиком позвоните по номеру телефона MESSA отдела обслуживания клиентов, указанному на обратной стороне Вашей карты.

Ukoliko je vama ili nekom kome pomažete potrebna pomoć, imate pravo dobiti pomoć I informaciju na vašem jeziku besplatno. Da biste razgovarali sa prevodiocem, pozovite broj za ulsuge članova MESSA na zadnjoj strani vaše kartice.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang interpreter, tumawag sa numero para sa mga serbisyo sa miyembro ng MESSA na nasa likuran ng iyong card.

Important disclosure

MESSA and Blue Cross Blue Shield of Michigan (BCBSM) comply with federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. MESSA and BCBSM provide free auxiliary aids and services to people with disabilities to communicate effectively with us, including qualified sign language interpreters. If you need assistance, call MESSA's Member Service Center at 800.336.0013 or TTY 888.445.5614.

If you need help filing a grievance, MESSA's general counsel is available to help you. If you believe that MESSA or BCBSM failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, or by mail, phone, fax or email: General Counsel, MESSA, P.O. Box 2560, East Lansing, MI 48826-2560, 800.292.4910, TTY: 888.445.5613, fax: 517.203.2909 or CivilRights-GeneralCounsel@messa.org.

You can also file a civil rights complaint with the Office for Civil Rights on the web at OCRComplaint@hhs.gov, or by mail, phone or email: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, 800.368.1019, TTD: 800.537.7697, or OCRComplaint@hhs.gov.

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MESSA ABC & ABC 5 Tier RX

Plan 2

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Coverage for: Individual/Family | **Plan Type:** PPO

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Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at (https://www.healthcare.gov/coverage/preventive-care-benefits/).
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)	$4,000 Individual/ $8,000 Family	$8,000 Individual/ $16,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of network providers see (http://www.messa.org) or call MESSA at 800-336-0013		This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.		You can see the specialist you choose without a referral.

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	Specialist visit	No Charge	20% coinsurance	None
	Preventive care/ screening/ immunization	No Charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance	May require prior authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/druglists	Generic drugs	$10 copay/prescription for retail 34-day supply; $30 copay/prescription for retail or mail order 90-day supply	In-Network copay plus an additional 25% of the approved amount	Prior authorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. Mail order drugs are not covered out-of-network
	Preferred brand-name drugs	$40 copay/prescription for retail 34-day supply; $120 copay/prescription for retail or mail order 90-day supply	In-Network copay plus an additional 25% of the approved amount	
	Non-preferred brand-name drugs	$80 copay/prescription for retail 34-day supply; $240 copay/prescription for retail or mail order 90-day supply	In-Network copay plus an additional 25% of the approved amount	
	Exclusive Pharmacy Network for Generic and preferred brand-name specialty drugs	20% of the approved amount, but no more than $150 for each prescription for retail 30-day supply	Not covered	Prior authorization is required. Specialty drugs limited to a 15 or 30-day supply
	Exclusive Pharmacy Network for Non-preferred brand-name specialty drugs	20% of the approved amount, but no more than $300 for each prescription for retail 30-day supply	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
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If you need immediate medical attention	Emergency room care	No Charge	No Charge	None
	Emergency medical transportation	No Charge	No Charge	Mileage limits apply
	Urgent care	No Charge	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% coinsurance	Prior authorization is required.
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If you need behavioral health services (mental health and substance use disorder)	Outpatient services	No Charge	20% coinsurance	None
	Inpatient services	No Charge	20% coinsurance	Prior authorization is required.
If you are pregnant	Office visits	No Charge; deductible does not apply	20% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services cost share may apply. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No Charge	20% coinsurance	None
	Childbirth/delivery facility services	No Charge	20% coinsurance	None

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	Habilitation services	No Charge for Applied Behavior Analysis; No Charge for Physical, Speech and Occupational Therapy	20% coinsurance	Prior authorization is required for applied behavior analysis (ABA). Services rendered by an approved licensed behavior analyst (LBA) will apply the In-network cost-sharing.
	Skilled nursing care	No Charge	No Charge	Physician certification required. Limited to 120 days per member per calendar year
	Durable medical equipment	No Charge	No Charge	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge	No Charge	Physician certification required. Unlimited visits.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental care (Adult)
- Long term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture treatment
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See (http://www.messa.org)
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling 1-800-324-6172. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact MESSA by calling 1-800-336-0013.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or http://www.michigan.gov/difs or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: **See Addendum**

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,070**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,520**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies)*
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or coinsurance, or benefits not otherwise covered.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Language services

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call MESSA's Member Service Center at 800.336.0013 or TTY 888.445.5614.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de servicios para miembros de MESSA, que aparece en la parte trasera de su tarjeta.

إذا كنت أنت أو شخص آخر تساعده بحاجة إلى المساندة، فمن حقّك الحصول على المساعدة والمعلومات بلغتك بدون أيّ كلفة. للتحدّث إلى مترجم، اتّصل بالرقم المخصّص لخدمات أعضاء MESSA الموجود على ظهر بطاقتك.

如果您，或是您正在協助的對象，需要協助，您有權利免費已您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的MESSA會員服務電話。

Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ, cần sự giúp đỡ, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, hãy gọi đến số dịch vụ thành viên MESSA trên mặt sau của thẻ.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e shërbimit të anëtarësimit MESSA në anën e pasme të kartës tuaj.

귀하 또는 귀하가 도움을 제공하는 누군가가 도움이 필요한 경우, 귀하는 귀하의 모국어로 무료로 도움과 정보를 제공 받을 권리를 갖고 있습니다. 통역사의 도움을 받으려면 카드 뒷면의 MESSA 회원 서비스 번호로 전화하십시오.

[illegible] MESSA [illegible]

যদি আপনার বা আপদন সাহাযয কররন এমন কাররা সহাযতার প্ররযাজন হয, তাহরে ককারনা খরচ ছাড়াই আপনার ভাষায় সহাযতা ও তথ্য পাওযার অদিকার ররযরছ। ককারনা কিাভাষীর সারথ্ কথ্া বেরত, আপনার কারডের কপছরন প্রিত MESSA সিসয পদররষবার নম্বরর কে করুন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi członków MESSA wskazany na odwrocie Twojej karty.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigen, haben Sie das Recht kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer der MESSA-Mitgliederbetreuung auf der Rückseite Ihrer Karte an. Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere gratuitamente aiuto e informazioni nella tua lingua. Per parlare con un interprete, chiama il numero del servizio membri MESSA presente sul retro della tua tessera.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたMESSAメンバーサービスの電話番号までお電話ください。

Если Вам или лицу, которому Вы помогаете, нужна помощь, то Вы имеете право на бесплатное получение помощи и информации на Вашем языке. Для разговора с переводчиком позвоните по номеру телефона MESSA отдела обслуживания клиентов, указанному на обратной стороне Вашей карты.

Ukoliko je vama ili nekom kome pomažete potrebna pomoć, imate pravo dobiti pomoć I informaciju na vašem jeziku besplatno. Da biste razgovarali sa prevodiocem, pozovite broj za ulsuge članova MESSA na zadnjoj strani vaše kartice.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang interpreter, tumawag sa numero para sa mga serbisyo sa miyembro ng MESSA na nasa likuran ng iyong card.

Important disclosure

MESSA and Blue Cross Blue Shield of Michigan (BCBSM) comply with federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. MESSA and BCBSM provide free auxiliary aids and services to people with disabilities to communicate effectively with us, including qualified sign language interpreters. If you need assistance, call MESSA's Member Service Center at 800.336.0013 or TTY 888.445.5614.

If you need help filing a grievance, MESSA's general counsel is available to help you. If you believe that MESSA or BCBSM failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, or by mail, phone, fax or email: General Counsel, MESSA, P.O. Box 2560, East Lansing, MI 48826-2560, 800.292.4910, TTY: 888.445.5613, fax: 517.203.2909 or CivilRights-GeneralCounsel@messa.org.

You can also file a civil rights complaint with the Office for Civil Rights on the web at OCRComplaint@hhs.gov, or by mail, phone or email: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, 800.368.1019, TTD: 800.537.7697, or OCRComplaint@hhs.gov.

MESSA ABC Plan 2
Medical plan highlights

MESSA
1475 Kendale Blvd. PO Box 2560
East Lansing, Michigan 48826-2560
517-332-2581 ● 800-292-4910

Effective Date: 1/1/2026

MESSA Account: Utica Community Schools

Employee Group: Teachers Health Professiona

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 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
Annual deductible The amount you pay for health care services and prescription drug purchases before your health insurance begins to pay. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31.	Single coverage: $2000 2-Person & Family coverage: $4000 When two or more lives are covered under this plan, the entire family deductible must be met before claims are paid for any individual.
Medical coinsurance A fixed percentage you pay for a medical service.	0%
Prescription drug coverage Under federal law governing HSA-eligible plans, prescription drugs are subject to the deductible (other than MESSA's free preventive prescriptions). After deductible is met, applicable prescription copayments and/or coinsurance apply. See free preventive prescriptions below.	3-Tier Rx
Annual out-of-pocket maximums The most you have to pay for covered medical services and prescriptions in a calendar year, including deductible, copayments and coinsurance. Charges above approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximum.	Single coverage: $4000 2-Person & Family coverage: $8000 Your out-of-pocket maximum is subject to change each Jan.1 to align with IRS adjustments.
In-network services covered at no cost to you	
Free preventive prescriptions MESSA ABC covers an extensive list of free preventive prescriptions that have no deductible, copayment or coinsurance, including cholesterol and blood pressure medications, weight loss medications, prenatal vitamins, contraceptives and many more.	No cost to you
Preventive care Certain services such as annual exams, screenings, childhood and adult immunizations, and certain preventive medications.	
Prenatal and postnatal care Prenatal and postnatal doctor visits.	

In-network services subject to deductible and applicable coinsurance

Acupuncture Must be performed by an M.D. or D.O or a registered acupuncturist.	**Allergy testing and therapy**
Ambulance	**Autism - applied behavior analysis (ABA) services**
Bariatric Surgery	**Chiropractic services including modalities** Up to 38 visits per calendar year.
Diagnostic lab and X-ray	**Durable medical equipment (DME)**
Hearing aids There is a maximum benefit for a hearing aid for each ear during a 36-month period.	**Hearing care** Hearing related services performed by an M.D. or D.O.
Home health care	**Hospital emergency room (ER)**
Human organ transplant Must be performed at an approved facility.	**Inpatient hospital**
Medical supplies	**Mental health and substance abuse - inpatient and outpatient care**
Office visit	**Osteopathic manipulations** Performed by an Osteopathic physician. Up to 38 visits per calendar year.
Outpatient physical, occupational and speech therapy Up to a combined benefit maximum of 60 visits per individual per calendar year.	**Prosthetics and orthotics**
Radiation and chemotherapy	**Skilled nursing facility** Up to a maximum of 120 days per calendar year.
Teladoc Health visits 24/7 care for minor illnesses, injuries and mental health; virtual primary care visits.	**Urgent Care**

Home delivery of prescription medications

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 messa.org 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.

Medical care outside the U.S.

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 (www.bcbsglobalcore.com) to find in-network providers prior to your departure.

Covered services and approved amounts

In-network providers 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.

Out-of-network providers 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.

Medical benefits underwritten by Blue Cross Blue Shield of Michigan (BCBSM) & 4 Ever Life Insurance Company. BCBSM is an independent licensee of the Blue Cross and Blue Shield Association.

Life and accidental death & dismemberment insurance

Life insurance: $5,000 policy for you.

Accidental death & dismemberment insurance (AD&D): $5,000 policy for you.

Life and AD&D insurance underwritten by Life Insurance Company of North America.

MESSA ABC Plan 2
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1475 Kendale Blvd. PO Box 2560
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Medical coinsurance A fixed percentage you pay for a medical service.	0%
Prescription drug coverage Under federal law governing HSA-eligible plans, prescription drugs are subject to the deductible (other than MESSA's free preventive prescriptions). After deductible is met, applicable prescription copayments and/or coinsurance apply. See free preventive prescriptions below.	5-Tier Rx
Annual out-of-pocket maximums The most you have to pay for covered medical services and prescriptions in a calendar year, including deductible, copayments and coinsurance. Charges above approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximum.	Single coverage: $4000 2-Person & Family coverage: $8000 Your out-of-pocket maximum is subject to change each Jan.1 to align with IRS adjustments.
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Prenatal and postnatal care Prenatal and postnatal doctor visits.	

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Diagnostic lab and X-ray	**Durable medical equipment (DME)**
Hearing aids There is a maximum benefit for a hearing aid for each ear during a 36-month period.	**Hearing care** Hearing related services performed by an M.D. or D.O.
Home health care	**Hospital emergency room (ER)**
Human organ transplant Must be performed at an approved facility.	**Inpatient hospital**
Medical supplies	**Mental health and substance abuse - inpatient and outpatient care**
Office visit	**Osteopathic manipulations** Performed by an Osteopathic physician. Up to 38 visits per calendar year.
Outpatient physical, occupational and speech therapy Up to a combined benefit maximum of 60 visits per individual per calendar year.	**Prosthetics and orthotics**
Radiation and chemotherapy	**Skilled nursing facility** Up to a maximum of 120 days per calendar year.
Teladoc Health visits 24/7 care for minor illnesses, injuries and mental health; virtual primary care visits.	**Urgent Care**

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Out-of-network providers 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.

Medical benefits underwritten by Blue Cross Blue Shield of Michigan (BCBSM) & 4 Ever Life Insurance Company. BCBSM is an independent licensee of the Blue Cross and Blue Shield Association.

Life and accidental death & dismemberment insurance

Life insurance: $5,000 policy for you.

Accidental death & dismemberment insurance (AD&D): $5,000 policy for you.

Life and AD&D insurance underwritten by Life Insurance Company of North America.

PO Box 610
Southfield, MI 48037
248-901-3705

UTICA COMMUNITY SCHOOLS Dental Benefits Plan — Group #9210

Teachers with Other Dental Plan Coverage

Please note: if it is discovered your other coverage has ended you will be moved from the coordinating dental plan to the non-coordinating dental plan with Utica. If your other coverage has ended please notify ADN Administrators and your Provider.

The Plan-at-a-Glance	PPO Networks: ADN Dental Network, DenteMax
Maximum Benefits	**July 1 through June 30**
Annual Maximum	$3,000 per eligible individual for covered class I, II and III services.
Lifetime Maximum - dependent child to age 25	$UCR per eligible dependent for covered class IV services
Lifetime Maximum - employee, spouse	$2,300 per eligible employee, spouse for covered class IV services
Class I Preventive Services – 50%	
Oral Examinations & Evaluations	Twice per plan year (regardless of specialty)
Prophylaxis (Cleaning)	Four per plan year (includes Periodontal Maintenance)
Topical Application of Fluoride	Twice per plan year to age 19
Bitewing X-Rays	Once per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 60 months
All Other X-Rays	
Space Maintainers	Once per area per lifetime, up to age 14
Class II Restorative Services – 50%	
Sealant Application	Once per 1st permanent molar to age 9 and 2nd permanent molar to age 14
Composite and Amalgam fillings	Once per tooth surface per 24 months
Onlays and Crowns**	Once per permanent tooth per 60 months
Root Canal Therapy	
Periodontal Maintenance	Four per plan year, following perio treatment (includes Prophylaxis)
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Once per quadrant per 36 months
Oral Surgery and Extractions	Medical plan primary for certain procedures
General Anesthesia or IV Sedation	With covered oral surgery or medically necessary
Occlusal Guards	Once per lifetime
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 36 months, per arch
Class III Major Services – 50%	
Complete and Partial Removable Dentures**	Once per arch per 60 months
Fixed Partial Dentures (Bridges)**	Once per area per 60 months
Addition of Teeth to Partial Dentures	
Endosteal Implants	Once per permanent tooth per 60 months
Class IV Orthodontic Services – 50%	**Effective 1/1/23: age and maximum limits above[1]**
Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy
Comprehensive Treatment	Fixed Appliance Therapy

Not Covered

Eposteal & Transosteal Implants — TMJ/TMD Treatment — Cosmetic Treatment

Deductible – None
Missing Tooth Clause – None
12 Month Billing Limitation
Waiting Periods – None
COB – Not Allowed

**Porcelain and ceramic not covered for posterior teeth, alternate benefit applies
**Prosthetics are considered on delivery date

[1]Orthodontic treatment begun prior to 1/1/2023 will remain at previous age and lifetime limits: UCR limit without age restriction for eligible individuals for covered Class IV services.

****Note – Quotes of benefits do not constitute a guarantee of payment. Eligibility is determined at time of service. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitation. Benefits are payable at the applicable percentage level of the Usual and Customary or PPO Fee Schedule allowed amount for the procedure rendered. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding $250.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

Updated 1/1/2023

PO Box 610
Southfield, MI 48037
248-901-3705

UTICA COMMUNITY SCHOOLS Dental Benefits Plan — Group #9210

Teachers without Other Dental Plan Coverage

Please note: If you have other dental coverage you will be moved from the non-coordinating dental plan to the coordinating dental plan with Utica. If you have other coverage please notify ADN Administrators and your Provider

The Plan-at-a-Glance	PPO Networks: ADN Dental Network, DenteMax
Maximum Benefits	**July 1 through June 30**
Annual Maximum	$3,000 per eligible individual for covered class I, II and III services.
Lifetime Maximum dependent child to age 25	$UCR per eligible dependent for covered class IV services
Lifetime Maximum employee, spouse	$2,300 per eligible employee, spouse for covered class IV services
Class I Preventive Services – 100%	
Oral Examinations & Evaluations	Twice per plan year (regardless of specialty)
Prophylaxis (Cleaning)	Four per plan year (includes Periodontal Maintenance)
Topical Application of Fluoride	Twice per plan year to age 19
Bitewing X-Rays	Once per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 60 months
All Other X-Rays	
Space Maintainers	Once per area per lifetime, up to age 14
Class II Restorative Services – 90%	
Sealant Application	Once per 1st permanent molar to age 9 and 2nd permanent molar to age 14
Composite and Amalgam fillings	Once per tooth surface per 24 months
Onlays and Crowns**	Once per permanent tooth per 60 months
Root Canal Therapy	
Periodontal Maintenance	Four per plan year, following perio treatment (includes Prophylaxis)
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Once per quadrant per 36 months
Oral Surgery and Extractions	Medical plan primary for certain procedures
General Anesthesia or IV Sedation	With covered oral surgery or medically necessary
Occlusal Guards	Once per lifetime
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 36 months, per arch
Class III Major Services – 90%	
Complete and Partial Removable Dentures**	Once per arch per 60 months
Fixed Partial Dentures (Bridges)**	Once per area per 60 months
Addition of Teeth to Partial Dentures	
Endosteal Implants	Once per permanent tooth per 60 months
Class IV Orthodontic Services – 90%	**Effective 1/1/23: age and maximum limits above[1]**
Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy
Comprehensive Treatment	Fixed Appliance Therapy

Not Covered

Eposteal & Transosteal Implants — TMJ/TMD Treatment — Cosmetic Treatment

Deductible – None
Missing Tooth Clause – None
12 Month Billing Limitation
Waiting Periods – None
COB – Not Allowed

**Porcelain and ceramic not covered for posterior teeth, alternate benefit applies
**Prosthetics are considered on delivery date

[1]Orthodontic treatment begun prior to 1/1/2023 will remain at previous age and lifetime limits: UCR limit without age restriction for eligible individuals for covered Class IV services.

****Note – Quotes of benefits do not constitute a guarantee of payment. Eligibility is determined at time of service. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitation. Benefits are payable at the applicable percentage level of the Usual and Customary or PPO Fee Schedule allowed amount for the procedure rendered. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding $250.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

Updated 1/1/2023

VSP 2 S Benefits

MESSA
1475 Kendale Blvd. PO Box 2560
East Lansing, Michigan 48826-2560
517-332-2581 ● 800-292-4910

Effective Date: 1/1/2026

MESSA Account: Utica Community Schools

Employee Group: Teachers Health Professiona

In-network providers

Most eye doctors are in VSP's Signature network. Staying in-network makes sure you get the most value from your benefits and limits your out-of-pocket costs. In-network doctors bill VSP directly as a convenience to you. A directory of Signature network doctors is available at messa.org or vsp.com. Call VSP member services at 800-877-7195 for assistance.

Out-of-network providers
(Maximum reimbursement to patient)

If you choose to see a doctor who is not in the VSP Signature network, your out-of-pocket costs will likely be higher and you must submit the itemized receipts to VSP for reimbursement. For more information, visit vsp.com or call VSP member services at 800-877-7195.

Benefit	In-network provider	Out-of-network provider maximum allowance
Examination		
Optometrist	$6.50 copayment	$28.50
Ophthalmologist		$38.50
Contact lenses (includes contact lens examination) *		
Elective lenses to improve vision	$110 allowance	$90
Medically necessary - *to correct keratoconus, irregular astigmatism, irregular corneal curvature or vision to 20/70 in the better eye*	MESSA pays 100% of the approved amount	$175
Eyeglass frames	$130 allowance after copayment	$44
Eyeglass lenses		
Single vision	$18 copayment	$29
Bifocal		$51
Trifocal		$63
Lenticular		$75
Eyeglass lens enhancements		
Rose #1 or #2 tint Rimless Oversize Blended Photochromic	MESSA pays 100% of the approved amount	Member must pay the difference between the approved amount and the provider charge
Progressive	Not covered	
Tinted		
Single vision	MESSA pays 100% of the approved amount	$33
Bifocal		$61
Trifocal		$75
Lenticular		$89
Polarized		
Single vision	MESSA pays 100% of the approved amount	$47
Bifocal		$81
Trifocal		$101
Lenticular		$119

*** The cost of the eye exam is covered separately and does not count against the contact lens allowance.**

MESSA Group Term Life Insurance plan highlights

Underwritten by Life Insurance Company of North America

MESSA
1475 Kendale Blvd. PO Box 2560
East Lansing, Michigan 48826-2560
517-332-2581 ● 800-292-4910

Effective Date: 01/01/2026

Account: Utica Community Schools

Employee Group: Teachers Health Professiona

This is a brief summary of your coverage available under MESSA's Group Term Life and AD&D policy. Please refer to your Life & Accident Insurance Certificate Booklet for complete information.

Plan features	Definition	Your Coverage
Group Term Life Insurance	The amount of your Group Term Life Insurance coverage.	$10,000
Group AD&D Insurance	The amount of your Accidental Death and Dismemberment (AD&D) coverage.	$10,000
Group Dependent Term Life Insurance: SPOUSE	This provides a life benefit equal to 50% of the member's benefit (not to exceed $25,000) for the spouse and does not contain AD&D benefits.	N/A
Group Dependent Term Life Insurance: CHILD(REN)	This provides a life benefit equal to 25% of the member's benefit (not to exceed $12,500) for all eligible children and does not contain AD&D benefits.	N/A

It is important to note that Group Term Life Insurance in excess of $50,000 and Group Dependent Term Life Insurance (if the benefit exceeds $2,000) are taxable benefits.

MESSA Group Term Life Insurance plan highlights

Underwritten by Life Insurance Company of North America

MESSA
1475 Kendale Blvd. PO Box 2560
East Lansing, Michigan 48826-2560
517-332-2581 ● 800-292-4910

Effective Date: 01/01/2026

Account: Utica Community Schools

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This is a brief summary of your coverage available under MESSA's Group Term Life and AD&D policy. Please refer to your Life & Accident Insurance Certificate Booklet for complete information.

Plan features	Definition	Your Coverage
Group Term Life Insurance	The amount of your Group Term Life Insurance coverage.	$20,000
Group AD&D Insurance	The amount of your Accidental Death and Dismemberment (AD&D) coverage.	$20,000
Group Dependent Term Life Insurance: SPOUSE	This provides a life benefit equal to 50% of the member's benefit (not to exceed $25,000) for the spouse and does not contain AD&D benefits.	N/A
Group Dependent Term Life Insurance: CHILD(REN)	This provides a life benefit equal to 25% of the member's benefit (not to exceed $12,500) for all eligible children and does not contain AD&D benefits.	N/A

It is important to note that Group Term Life Insurance in excess of $50,000 and Group Dependent Term Life Insurance (if the benefit exceeds $2,000) are taxable benefits.

MESSA Group LTD Plan Benefit Highlights

Underwritten by Life Insurance Company of North America

MESSA
1475 Kendale Blvd. PO Box 2560
East Lansing, Michigan 48826-2560
517-332-2581 ● 800-292-4910

Effective Date: 01/01/2026

Account: Utica Community Schools

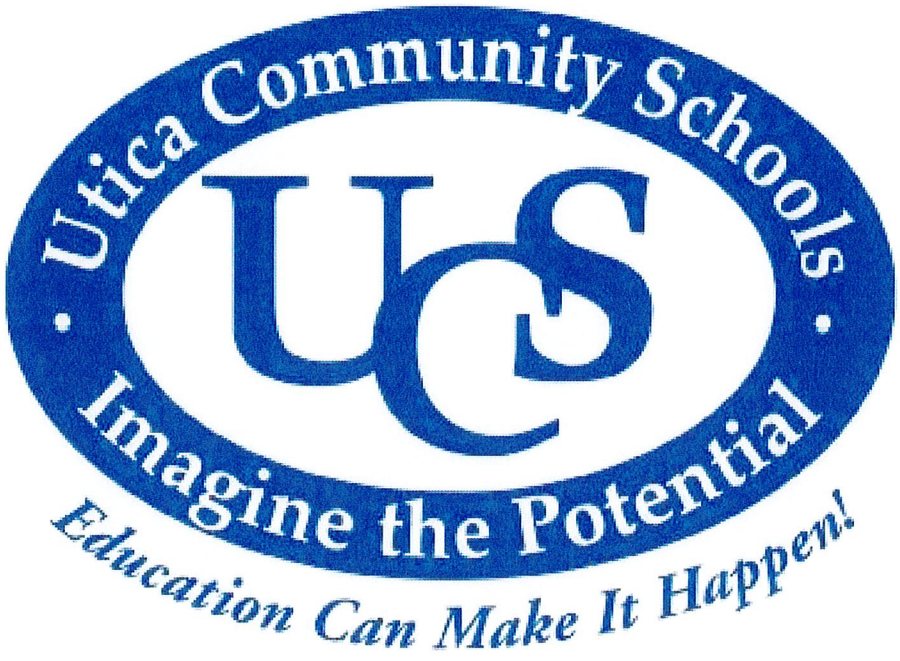
Employee Group: Teachers Health Professiona

Long Term Disability (LTD) insurance provides benefits at a percentage of a member's salary in the event of total disability. Benefits begin after the satisfaction of a waiting period and continue as long as the member remains totally disabled as described under "Maximum Benefit Period" in the LTD certificate booklet.
This is a brief summary of your coverage available under MESSA's Group LTD insurance. Refer to the actual certificate booklet for complete information.

Plan Features	Definition	Your Coverage
Pre-Existing Conditions	Medical conditions for which the advice or treatment was received prior to effective date of coverage are included. However, doctor-verified disabilities in effect prior to the effective date would be excluded.	Waived
Waiting Period	*Calendar Day (CD):* The waiting period is based on actual calendar days. *Work Day (WD):* The waiting period is based on the consecutive number of contracted work days. *Modified Fill (MF):* Benefits begin on the latter of exhaustion of sick time/ bank or the specified number of calendar/work day waiting period. *Straight Wait (SW):* Benefits begin after the specified number of calendar/ work day waiting period.	365 CDMF
Benefit Level	Percent of covered salary.	60%
Maximum Benefit Level	Monthly benefit up to the maximum amount bargained.	$4,500
Minimum Maximum Benefit	There is a minimum monthly benefit of 5% of the gross monthly benefit or $50, whichever is greater, after all offsets are applied, not to exceed the maximum monthly benefit.	5%
Offsets	Benefits are reduced by any income the employee receives or is entitled to receive such as vacation pay, salary continuation, workers' compensation, full auto wage loss benefit, any employer-paid group plan, retirement benefits you receive from your employer's retirement or pension plan, including Michigan Public School Employees' Retirement System (MPSERS), short-term disability, and others.	
Social Security Offsets	*Primary*: Social security retirement and social security disability are offsets. *Family:* Any social security disability benefits received by the employee's family due to the employee's disability is an offset.	Family
Freeze on Offsets	Monthly disability benefits will not be reduced because of automatic, statutory or general cost of living increases in income from other sources after MESSA's initial benefit determination for each specified offset has been made. The exception to this is an unsuccessful return to work with increased salary, social security and retirement cost of living.	Yes
COLA	An employee's benefit may be increased while on claim due to increase in the cost of living. The increase is based on changes in the Consumer Price Index as of January 1 each year and is payable on the anniversary of the commencement of benefit payment. There is a maximum annual increase of 3%.	No
Own Occupation Maximum Benefit Period	Disability benefits may be payable during continuous disability. After the own occupation period, a member must be unable to perform any occupation for which he/she is qualified by training, experience or education. Benefits may be payable up to age 65. For benefits commencing at or after age 60, please see your benefit schedule.	2 Years
Mental / Nervous Conditions	These conditions are covered as any other illness unless you have a 2-year aggregate limitation.	2-year limitation
Alcoholism / Drug Abuse	These conditions are covered as any other illness unless you have a 2-year aggregate limitation.	2-year limitation

For additional information please call MESSA's Disability Department at 800-247-6951.

GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PROGRAM



GROUP LIFE INSURANCE

SCHEDULE OF BENEFITS

EFFECTIVE DATE: May 1, 2011, as amended in the Policy through July 1, 2015

ELIGIBLE CLASSES: Each active, Full-time Employee who is a member of the Utica Federation of Teachers, except any person employed on a temporary or seasonal basis.

INDIVIDUAL EFFECTIVE DATE: The first of the month following the day you become eligible.

INDIVIDUAL REINSTATEMENT: Not Applicable

AMOUNT OF INSURANCE:

Basic Life: $10,000.

The Life amount will be reduced by any benefit paid under the Living Benefit Rider.

CHANGES IN AMOUNT OF INSURANCE: Increases and decreases in the Amount of Insurance because of changes in age, class or earnings (if applicable) are effective on the first of the Policy month coinciding with or next following the date of the change.

With respect to increases in the Amount of Insurance, you must be Actively At Work on the date of the change. If you are not Actively At Work when the change should take effect, the change will take effect on the day after you have been Actively At Work for one full day.

CONTRIBUTIONS: You are not required to contribute toward the cost of the Basic Insurance.

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

SCHEDULE OF BENEFITS

ELIGIBILITY: Each active, Full-time Employee who is a member of the Utica Federation of Teachers, except any person employed on a temporary or seasonal basis.

INDIVIDUAL EFFECTIVE DATE: The first of the month following the day you become eligible.

INDIVIDUAL REINSTATEMENT: Not Applicable

AMOUNT OF INSURANCE: **PRINCIPAL SUM:**

INSURED PERSONS:

$10,000

CHANGES IN AMOUNT OF INSURANCE: Increases and decreases in the Amount of Insurance because of changes in age, class or Earnings (if applicable) are effective on the first of the Policy month coinciding with or next following the date of the change.

With respect to increases in the Amount of Insurance, you must be Actively at Work on the date of the change. If you are not Actively at Work when the change should take effect, the change will take effect on the day after you have been Actively at Work for one full day.

CONTRIBUTIONS: You are not required to contribute toward the cost of your insurance coverage.