2027

BENEFITS *Guide*







Mattawan Consolidated Schools

Admin, Transportation, Maintenance and Support Staff

MESSA®

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The details in this booklet are intended as an easy to read summary and provide only a general overview of the plan. It is not intended to be a contract. Additional limitations and exclusions may apply. If there is a discrepancy between this booklet and the applicable plan documents, the plan documents will prevail.

A guide to your MESSA benefits

2027 open enrollment is 10/12/2026 to 10/31/2026.

Dear Mattawan Consolidated Schools member:

The open enrollment period is your opportunity to review and update your health benefits selections for the coming year. It's important for you to understand the benefits available to you, so you can make the best decisions for you and your family.

This benefit guide provides an overview of your MESSA benefit options. Please review it carefully before making your benefit selections.

Once you're ready, you can log in to your MyMESSA account at messa.org to access the online benefits website. After open enrollment closes on 10/31/2026, you cannot change your benefit selections until the next open enrollment period.[1]

Any changes you make will become effective 01/01/2027.

If you have any questions, call MESSA's Member Service Center at 800-336-0013. We're here to help!

Access the online benefits website by logging in to your MyMESSA account at messa.org to:

- Review your current enrollment.
- Make any benefit selection changes.
- Submit benefit selection by 10/31/2026.

[1]Allowances are made for "qualifying events," such as marriage, birth, your spouse's losing coverage from another insurer, or other limited instances.

MESSA In-Network Plan Comparison - Effective 1/1/2027
Mattawan Consolidated Schools - 152A Admns,Trns,Maint,OfficePers

	MESSA Choices $500/$1,000 0% 3-Tier Rx	MESSA Choices $1,000/$2,000 10% 5-Tier Rx	MESSA ABC Plan 1 $1,750/$3,500 HSA 0% 3-Tier Rx	Essentials by MESSA $375/$750 20% EbM Rx
In-Network Cost Share After Deductible				
Deductible	$500/$1,000	$1,000/$2,000	$1,750/$3,500	$375/$750
Coinsurance	0%	10%	0%	20%
Teladoc 24/7 care for minor illnesses, injuries and mental health	$20	$20	0%	$10
Teladoc Health virtual primary care	$20	$20	0%	$25
Office visit	$20	$20	0%	$25
Specialist visit	$20	$20	0%	$50
Urgent care	$25	$25	0%	$50
Emergency room	$50	$50	0%	$200
Total out-of-pocket maximum	$3,500/$7,000	$5,000/$10,000	$3,750/$7,500	$12,000/$24,000
Certain Benefit Differences (cost share is applied after deductible is met)				
Chiropractic manipulations	38 visits per calendar year, including therapeutic massage; 100% after ded.	38 visits per calendar year, including therapeutic massage; 90% after ded.	38 visits per calendar year, including therapeutic massage; 100% after ded.	12 visits combined per calendar year; $25 copay applies
Osteopathic manipulations	38 visits per calendar year; 100% after ded.	38 visits per calendar year; 90% after ded.	38 visits per calendar year; 100% after ded.	
Outpatient physical, occupational and speech therapy	60 visits combined per calendar year; 100% after ded.	60 visits combined per calendar year; 90% after ded.	60 visits combined per calendar year; 100% after ded.	30 visits combined per calendar year, including therapeutic massage by an approved provider (excludes massage therapist); 80% after ded.
Bariatric surgery	100% after ded.	90% after ded.	100% after ded.	Not covered
Acupuncture	100% after ded.	90% after ded.	100% after ded.	Not covered
Hearing aids	100% up to a max. benefit after ded.	90% up to a max. benefit after ded.	100% up to a max. benefit after ded.	Not covered

Prescription Drugs	3-Tier Rx	5-Tier Rx	3-Tier Rx (after deductible)	Essentials by MESSA Rx
Up to a 34-day supply				
Generic	$10	$10	Free or $10	$10
Preferred brand	20% coinsurance ($40 min - $80 max)	$40	20% coinsurance ($40 min - $80 max)	20% coinsurance ($40 min - $80 max)
Nonpreferred brand	20% coinsurance ($60 min - $100 max)	$80	20% coinsurance ($60 min - $100 max)	20% coinsurance ($60 min - $100 max)
Preferred specialty (generic specialty and brand specialty)	Pricing included in one of the above categories	20% coinsurance ($0 min - $150 max)	Pricing included in one of the above categories	Pricing included in one of the above categories
Nonpreferred specialty		20% coinsurance ($0 min - $300 max)		
90-day supply				
Generic, Preferred brand, Nonpreferred brand	2.5x 1-month supply; Retail or mail order	3x 1-month supply; Retail or mail order	2.5x 1-month supply; Retail or mail order	3x 1-month supply; Retail or mail order
Additional Information				
Free preventive drug list(s)	ACA Free Preventive list. These are FREE before deductible.	ACA Free Preventive list. These are FREE before deductible.	ACA Free Preventive list and MESSA Expanded Free Preventive list. These are FREE before deductible.	ACA Free Preventive list. These are FREE before deductible.
Basic Term Life Insurance	$5,000 included	$5,000 included	$5,000 included	$5,000 included
Supplemental Plans	Not included	Not included	Not included	Not included

ACA = Affordable Care Act

Essentials by MESSA Rx, Balance+ Rx, and 5-Tier Rx plans have several drugs and drug categories that are excluded.

~ The out-of-pocket maximum (OOPM) for Essentials by MESSA, is subject to change each Jan. 1 according to the maximum limit allowed by the Affordable Care Act.

~ The MESSA ABC Plan 1 and Balance+ deductible is subject to change each Jan. 1 to remain HSA-compatible, per IRS rules; out-of-pocket maximums may change based on deductible amounts.

If you have any questions, please contact your MESSA Field Representative, Jim Gleason, at 866-637-0006.

This comparison is provided for informational purposes only and MESSA assumes no responsibility or liability for any errors or omissions in the content. Refer to MESSA.org and the plan booklets for additional information.

MESSA Choices with 3-Tier Rx Overview

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

Where you get your medication depends on which plan you have

Rx plan	Up to 34-day Rx	90-day Rx	Up to 30-day specialty Rx
Choices with 3-Tier Rx	Retail pharmacy	Retail pharmacy or Optum Rx (optional home delivery by mail)	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.
Choices with 3-Tier Rx and Mandatory Mail*	Retail pharmacy	Optum Rx (**required** home delivery by mail)	

***Note:** *The Choices with 3-Tier Rx and Mandatory Mail plan requires you to obtain certain long-term maintenance medications and 90-day prescriptions through Optum Rx. If a drug is on the list of medications requiring home delivery, it will not be covered if you obtain it from a retail pharmacy. You can go to a local pharmacy for short-term prescriptions, such as antibiotics or medications that have a limited supply.*

What you pay for a prescription from an in-network pharmacy

	Up to 34-day supply	90-day supply
Specific preventive medications mandated by federal law are covered 100%.	No cost to you	No cost to you
Generics	$10 copayment	$25 copayment
Preferred brand-name drugs	20% coinsurance $40 minimum – $80 maximum	20% coinsurance $100 minimum – $200 maximum
Nonpreferred brand-name drugs	20% coinsurance $60 minimum – $100 maximum	20% coinsurance $150 minimum – $250 maximum

Note:** *If the approved amount is less than the copayment, you pay only the approved amount for the drug.* ***Up to a 90-day supply of insulin may be obtained for the same amount as a 34-day supply from any in-network provider. *The amount you pay for brand-name medications varies because coinsurance is based on the price of the drug when filled. If you obtain a nonpreferred brand-name drug when a generic drug is available, you will pay the nonpreferred brand-name drug coinsurance plus the difference in cost between the generic drug and the nonpreferred brand-name drug. Prescription types (generic, brand-name and specialty) are subject to change without notice.*

Your prescription plan includes a number of money-saving features, including prior authorization, step therapy and quantity limits.

To order medications through Optum Rx log in to your MyMESSA account at 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.

GS | Rev. 08/02/24

MESSA Choices with 5-Tier Rx Overview

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- You pay copays or coinsurance on prescription medications until your prescription out-of-pocket maximum is reached.
- If the approved amount of a prescription medication 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. Additionally, brand-name drugs are not covered when a generic equivalent is available.
- If you have 5-Tier Rx with Mandatory Mail, 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** and select "Optum Rx home delivery" under the "Benefits" menu. 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.

Type of medications	Up to 34-day supply	90-day supply
Specific preventive medications mandated by federal law are covered 100%.	No cost to you	No cost to you
Generic drugs Members pay the lowest copay for generics, making them the most cost-effective option for treatment.	$10 copayment	$30 copayment
Preferred brand-name drugs Brand-name drugs are more expensive than generics.	$40 copayment	$120 copayment
Nonpreferred brand-name drugs Includes brand-name drugs for which there's either a generic alternative or a more cost-effective, preferred brand-name drug available.	$80 copayment	$240 copayment
Preferred specialty drugs Includes generic and brand-name specialty drugs that are used to treat difficult health conditions.	20% coinsurance with a maximum of $150 (up to 30-day supply)	Not available
Nonpreferred specialty drugs Includes nonpreferred brand-name specialty drugs that are used to treat difficult health conditions. Members pay more for nonpreferred specialty drugs because there are more cost-effective generic or preferred drugs available.	20% coinsurance with a maximum of $300 (up to 30-day supply)	Not available

Prescription types (generic, brand-name and specialty) are subject to change without notice. The initial quantity of select specialty drugs may be limited and ***your cost will be reduced accordingly for the reduced initial fill.*** *To fill your specialty medication prescription, call Walgreens Specialty Pharmacy at 866-249-5367.* ***Up to a 90-day supply of insulin may be obtained for the same amount as a 34-day supply from any in-network provider.***

MESSA ABC with 3-Tier Rx Overview

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If you have MESSA ABC with 3-Tier Rx and Mandatory Mail: You must order all 90-day prescriptions and certain long-term maintenance medications through Optum Rx for home delivery.

- You pay the full cost of your prescriptions until your deductible is fully paid. After deductible, you are responsible for prescription copayments or coinsurance until your 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.

	Up to 34-day supply	90-day supply
List of specific preventive medications in addition to those mandated by federal law are covered 100% with no deductible required.	No cost to you	No cost to you
After your deductible is met the following copayments apply:		
Generics	$10 copayment	$25 copayment
Preferred brand-name drugs	20% coinsurance $40 minimum – $80 maximum	20% coinsurance $100 minimum – $200 maximum
Nonpreferred brand-name drugs	20% coinsurance $60 minimum – $100 maximum	20% coinsurance $150 minimum – $250 maximum

The amount you pay for brand-name medications varies because coinsurance is based on the price of the drug when it is filled. If you obtain a nonpreferred brand-name drug when a generic drug is available, you will pay the nonpreferred brand-name drug coinsurance plus the difference in cost between the generic drug and the nonpreferred brand-name drug. Prescription types (generic, brand-name and specialty) are subject to change without notice. ***Up to a 90-day supply of insulin may be obtained for the same amount as a 34-day supply from any in-network provider.***

To order medications through Optum Rx, log in to your MyMESSA account at 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.

Essentials by MESSA In-network Rx Overview

MESSA
1475 Kendale Blvd., P.O. Box 2560
East Lansing, MI 48826-2560
517-332-2581 • 800-292-4910

What you pay for a prescription from an in-network pharmacy

	Up to 34-day supply	90-day supply
Specific preventive medications mandated by federal law are covered 100%	No cost to you	No cost to you
Generics	$10 copayment	$30 copayment
Preferred brand Most brand-name drugs with no generic equivalent or therapeutic alternative	20% coinsurance $40 minimum – $80 maximum	20% coinsurance $120 minimum – $240 maximum
Nonpreferred brand Brand-name drugs for which there's a generic alternative or preferred brand-name drug	20% coinsurance $60 minimum – $100 maximum	20% coinsurance $180 minimum – $300 maximum

The amount you pay for brand-name medications can vary because coinsurance is based on the price of the drug when it is filled. Prescription types (generic, brand-name and specialty) are subject to change without notice. Up to a 90-day supply of insulin may be obtained from the same amount as a 34-day supply for an in-network provider.

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. To fill your specialty medication prescription, call Walgreens Specialty Pharmacy at 866-249-5367.

Money-saving features of this plan

This prescription plan includes a number of money-saving features including prior authorization, step therapy and quantity limits. Additionally, brand-name drugs are not covered when a generic equivalent is available.

To help keep your costs down, some prescription drugs are not covered by this plan. These excluded drugs have preferred alternatives with similar effectiveness, quality and safety. If you fill a prescription for an excluded drug, you will pay the full retail price.

This is a brief overview of the Essentials by MESSA Rx plan. For additional information, including eligibility, limitations and exclusions, please contact MESSA at 800-336-0013.

VSP 3 G Benefits

MESSA
1475 Kendale Blvd. PO Box 2560
East Lansing, Michigan 48826-2560
517-332-2581 ● 866-637-0006

Effective Date: **01/01/2027**

MESSA Account: Mattawan Consolidated Schools

Employee Group: AdmnsTrnsMaintOfficePers

In-network providers	Out-of-network providers (Maximum reimbursement to patient)
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.	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	No copayment	$35
Ophthalmologist	No copayment	$45
Contact lenses (includes contact lens examination) *		
Elective lenses to improve vision	$135 allowance	$115
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	$200
Eyeglass frames	$130 allowance	$55
Eyeglass lenses		
Single vision	MESSA pays 100% of the approved amount	$38
Bifocal		$60
Trifocal		$72
Lenticular		$108
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	$42
Bifocal		$70
Trifocal		$84
Lenticular		$118
Polarized		
Single vision	MESSA pays 100% of the approved amount	$56
Bifocal		$90
Trifocal		$110
Lenticular		$138

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

MESSA resources

Member Service Center | 800-336-0013

Our Member Service Center is available Monday through Friday 8 a.m. to 5 p.m. Our member service specialists are experts at answering questions about your plan and helping with claims.

Your MESSA field representative | 800-292-4910

A local field representative is available to help you and your group. Your field representative can explain benefits and answer questions, attend meetings or arrange visits from other MESSA experts, including nurse educators.

Medical case management | 800-441-4626

MESSA's medical case management nurses can help members and dependents with a catastrophic injury or serious illness get access to the right care at the right time and return to their highest quality of life.

Health promotion consultant | 800-292-4910

MESSA's health promotion consultant can help you and your coworkers develop or strengthen a worksite wellness program.

Legal Notices

Privacy Practices

MESSA understands the importance of your protected health information (hereafter referred to as "PHI") and follows strict policies in accordance with state and federal privacy laws to keep your PHI private. PHI is information about you that can reasonably be used to identify you and information that relates to your past, present, or future physical or mental health, the provision of health care or the payment of that care. Notices of the Privacy Practices for MESSA, BCBSM, NYL and VSP can be found at **messa.org/privacy**.

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, please contact your employer.

You may have other options available to you when you lose group health coverage.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or;
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than their gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than their gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

MESSA will offer COBRA continuation coverage to qualified beneficiaries only after MESSA has been notified that a qualifying event has occurred. The employer must notify MESSA of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify MESSA within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?

Once MESSA receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

- ***Disability extension***
  If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify your employer in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months.

  The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.
- ***Second qualifying event extension***
  If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation of coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **medicare.gov/medicare-and-you**.

Questions?

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to your employer.

Keep your Plan informed of address changes

To protect your family's rights, let MESSA know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

You may also request group coverage for yourself or your dependents within 60 days of either of the following events:

- Your Medicaid coverage or your dependents' Children's Health Insurance Program (CHIP) coverage is terminated due to loss of eligibility; or
- You or your dependent becomes eligible for premium subsidies.

To request special enrollment or obtain more information, contact your MESSA field representative at 800-292-4910, ext. 7817.

Newborns' and Mothers' Health Protection Act Notice

Under the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), group health

plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your MESSA field representative at 800-292-4910, ext. 7817.

Michelle's Law

Notice of extended coverage to participants covered under a group health plan

Federal legislation known as "Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year.

Your Plan permits an employee to continue a child's coverage if that child is enrolled at an accredited institution of learning on a full-time basis, with full-time defined by the accredited institution's registration and/or attendance policies. Michelle's Law requires the Plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for Plan coverage due to loss of full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- Dependent child means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his/her student status and who was enrolled at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.
- Medically necessary leave of absence means a leave of absence or any other change in enrollment of a dependent child from a post-secondary educational institution that:
  - Begins while the child is suffering from a serious illness or injury
  - Is medically necessary; and
  - Causes the dependent child to lose student status under the terms of the Plan

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

- If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:
- One year after the first day of the leave of absence; or

- The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student).

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more information regarding the criteria for medical necessity determinations with respect to mental health or substance use disorder benefits, please contact MESSA's Member Service Center at 800-336-0013.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs. However, you may be able to buy individual insurance coverage through the Health Insurance Marketplace; for more information, visit **healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed in this section, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are not currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office by calling **877-KIDS NOW (877-543-7669)** or by going online to **insurekidsnow.gov** to find out how to apply. If you qualify, ask if your state has a program that might help you pay the premiums or an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity. **You must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your state for more information on eligibility.

ALABAMA — MEDICAID
Website: **myalhipp.com**
Phone: 855-692-5447

ALASKA — Medicaid
The AK Health Insurance Premium Payment Program
Website: **myakhipp.com**
Phone: 866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid eligibility: **health.alaska.gov/dpa/Pages/default.aspx**

ARKANSAS — Medicaid
Website: **myarhipp.com**
Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA — Medicaid
Health Insurance Premium Payment (HIPP) Program website: **dhcs.ca.gov/hipp**
Fax: 916-440-5676
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

COLORADO — Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado website: **healthfirstcolorado.com**
Health First Colorado Member Contact Center: 800-221-3943/State Relay 711
CHP+: **hcpf.colorado.gov/child-health-plan-plus**
CHP+ Customer Service: 800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): **mycohibi.com/HIBI**
HIBI Customer Service: 855-692-6442

FLORIDA — Medicaid
Website: **flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**
Phone: 877-357-3268

GEORGIA — Medicaid
GA HIPP website: **medicaid.georgia.gov/healthinsurance-premium-payment-program-hipp**
Phone: 678-564-1162, Press 1
GA CHIPRA website: **medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorizationact-2009-chipra**
Phone: 678-564-1162, Press 2

INDIANA — Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: **in.gov/medicaid/ in.gov/fssa/dfr/**
Family and Social Services Administration
Phone: 800-403-0864
Member Services Phone: 800-457-4584

IOWA — Medicaid and CHIP (Hawki)
Medicaid website: **Iowa Medicaid | Health & Human Services**
Medicaid phone: 800-338-8366
Hawki website: **Hawki - Healthy and Well Kids in Iowa | Health & Human Services**
Hawki Phone: 800-257-8563
HIPP website: **Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)**
HIPP phone: 888-346-9562

KANSAS — Medicaid
Website: **kancare.ks.gov**
Phone: 800-792-4884
HIPP Phone: 800-967-4660

KENTUCKY — Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) website: **chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx**
Phone: 855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP website: **kynect.ky.gov**
Phone: 877-524-4718
Kentucky Medicaid website: **chfs.ky.gov/agencies/dms**

LOUISIANA — Medicaid
Website: **medicaid.la.gov**
Phone: 888-342-6207 (Medicaid hotline)
Website: **ldh.la.gov/lahipp**
Phone: 855-618-5488 (LaHIPP)

MAINE — Medicaid
Enrollment website: **mymaineconnection.gov/benefits/s/?language=en_US**
Phone: 800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium webpage: **maine.gov/dhhs/ofi/applications-forms**
Phone: 800-977-6740
TTY: Maine relay 711

MASSACHUSETTS — Medicaid and CHIP
Website: **mass.gov/masshealth/pa**
Phone: 800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA — Medicaid
Website: **mn.gov/dhs/health-care-coverage/**
Phone: 800-657-3672

MISSOURI — Medicaid
Website: **dss.mo.gov/mhd/participants/pages/hipp.htm**
Phone: 573-751-2005

MONTANA — Medicaid
Website: **dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**
Phone: 800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA — Medicaid
Website: **ACCESSNebraska.ne.gov**
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA — Medicaid
Website: **dhcfp.nv.gov**
Phone: 800-992-0900

NEW HAMPSHIRE — Medicaid
Website: **dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**
Phone: 603-271-5218
Toll-free: 800-852-3345 ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY — Medicaid and CHIP
Medicaid website: **state.nj.us/humanservices/dmahs/clients/medicaid**
Phone: 800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: **njfamilycare.org/index.html**
CHIP Phone: 800-701-0710 (TTY: 711)

NEW YORK — Medicaid
Website: **health.ny.gov/health_care/medicaid**
Phone: 800-541-2831

NORTH CAROLINA — Medicaid
Website: **medicaid.ncdhhs.gov**
Phone: 919-855-4100

NORTH DAKOTA — Medicaid
Website: **hhs.nd.gov/healthcare**
Phone: 844-854-4825

OKLAHOMA — Medicaid and CHIP
Website: **insureoklahoma.org**
Phone: 888-365-3742

OREGON — Medicaid
Websites: **healthcare.oregon.gov/Pages/index.aspx**
Phone: 800-699-9075

PENNSYLVANIA — Medicaid and CHIP
Website: **pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html**
Phone: 800-692-7462
CHIP website: **Children's Health Insurance Program (CHIP) (pa.gov)**
CHIP Phone: 800-986-KIDS (5437)

RHODE ISLAND — Medicaid and CHIP
Website: **eohhs.ri.gov**
Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA — Medicaid
Website: **scdhhs.gov**
Phone: 888-549-0820

SOUTH DAKOTA — Medicaid
Website: **dss.sd.gov**
Phone: 888-828-0059

TEXAS — Medicaid
Website: **hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program**
Phone: 800-440-0493

UTAH — Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
Website: **medicaid.utah.gov/upp/**
Email: upp@utah.gov
Phone: 888-222-2542
Adult Expansion Website: **medicaid.utah.gov/expansion/**
Utah Medicaid Buyout Program Website: **medicaid.utah.gov/buyout-program/**
CHIP Website: **chip.utah.gov/**

VERMONT — Medicaid
Website: **dvha.vermont.gov/members/medicaid/hipp-program**
Phone: 800-250-8427

VIRGINA — Medicaid and CHIP
Websites: **coverva.dmas.virginia.gov/learn/premiumassistance/famis-select**
coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 800-432-5924

WASHINGTON — Medicaid
Website: **hca.wa.gov**
Phone: 800-562-3022

WEST VIRGINIA — Medicaid and CHIP
Website: **dhhr.wv.gov/bms/**
mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN — Medicaid and CHIP
Website: **dhs.wisconsin.gov/badgercareplus/p-10095.htm**
Phone: 800-362-3002

WYOMING — Medicaid
Website: **health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility**
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July, 31, 2024, or for more information on special enrollments rights, contact either of the following:

U. S. Department of Labor
Employee Benefits Security Administration
Website: **dol.gov/agencies/ebsa**
Phone: 866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Website: **cms.hhs.gov**
Phone: 877-267-2323, menu option 4, ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

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 حقك الحصول على المساعدة والمعلومات بلغتك بدون أي كلفة. للتحدث إلى مترجم، اتصل بالرقم المخصص 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.

MESSA ,ہو ! مدد کی ضرورت ہے ،آپ کسی ایسے شخص کی مدد کر رہے ہیں جسے مدد کی ضرورت ہے اور ،آپ کو مفت میں اپنی زبان میں مدد اور معلومات حاصل کرنے کا حق حاصل ہے۔ ترجمان سے بات کرنے کے لئے، اپنے کارڈ کی پشت پر درج MESSA کی ممبر سروس سینٹر کو کال کریں۔

যদি আপনার বা আপনি সাহায্য করেন এমন কারো সহায়তার প্রয়োজন হয়, তাহলে কোনো খরচ ছাড়াই আপনার ভাষায় সহায়তা ও তথ্য পাওয়ার অধিকার রয়েছে। কোনো দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে প্রদত্ত MESSA সদস্য পরিষেবার নম্বরে কল 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.

Appendix

The information contained in this appendix is not intended, nor should it be interpreted, as an endorsement or recommendation of the third-party products and services contained herein. MESSA is not affiliated, associated or in any way officially connected to these products or services. Additionally, MESSA makes no guarantee regarding the accuracy or reliability of the content. All trademarks and service marks identifying third-party providers are the property of their respective owners.

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

[redacted]

Mattawan Consolidated Schools Dental Benefits Plan

Administrators, Teachers

The Plan-at-a-Glance	PPO Networks: ADN Dental Network, DenteMax
Maximum Benefits	**Plan Year January 1 through December 31**
Annual Maximum	$1500 per eligible individual for covered class I, II and III services.
Lifetime Ortho Maximum	$3000 per eligible individual for covered class IV services
Class I Preventive Services – 90%	
Routine Oral Examinations	Twice per plan year
Prophylaxis/Periodontal Maintenance (Cleaning)	Twice per plan year
Topical Application of Fluoride	Once per plan year to age 19
Bitewing X-Rays	Once per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 36 months
All Other X-Rays	
Sealants	Once per 24 months, 1st & 2nd permanent molars, to age 14
Space Maintainers	Once per quadrant per lifetime, up to age 19
Class II Restorative Services – 90%	
Composite and Amalgam fillings*	Once per tooth surface per 24 months
Root Canal Therapy	
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Once per quadrant per 36 months
Oral Surgery and Extractions	
General Anesthesia or IV Sedation	With covered Oral Surgery or medically necessary
Occlusal Guards	Once per 24 months (bruxism only)
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 60 months, per arch
Class III Major Services – 90%	
Inlays, Onlays and Crowns**	Once per permanent tooth per 60 months
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	
Implants	Once per permanent tooth per 60 months
Class IV Orthodontic Services – 90%	
Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy, up to age 19
Comprehensive Treatment	Fixed Appliance Therapy, up to age 19
Not Covered	
TMJ/TMD Treatment	Cosmetic Treatment

Deductible –None
Missing Tooth Clause – None
12 Month Billing Limitation
Waiting Periods – None
COB – Standard

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

****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.**