

Summary of Benefits and Coverage: What this Plan Covers & What it Costs*

Coverage Period: Beginning on or after January 1
Coverage for: Individual / Family | Plan Type: PPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.messa.org or by calling MESSA at 800-336-0013.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall <u>deductible</u>?	\$2,000 Individual/ \$4,000 Family	\$4,000 Individual / \$8,000 Family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	No.	You don't have to meet deductibles for specific services, but see the Common Medical Event chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	\$3,000 Individual/ \$6,000 Family	\$6,000 Individual / \$12,000 Family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u>?	Premiums, balance-billed charges, and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.		The Common Medical Events chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes. For a list of in-network providers, see www.messa.org or call MESSA at 800-336-0013.		If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the Common Medical Events Chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u>?	No.		You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.		Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

MESSA ABC, Group Number 71452, 71453; 163 164

Questions: Call MESSA at 800-336-0013 or visit us at www.messa.org. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/healthreform> or call MESSA at 800-336-0013 to request a copy.

*This plan or selected benefits within this plan are underwritten by 4 Ever Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association and administered by Blue Cross Blue Shield of Michigan.



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge after deductible	20% co-insurance after deductible	---none---
	Specialist visit	No Charge after deductible	20% co-insurance after deductible	---none---
	Other practitioner office visit	No Charge after deductible for chiropractor	20% co-insurance after deductible	Limited to a maximum of 38 visits per member per calendar year for spinal manipulations.
	Preventive care/screening/immunization	No Charge	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	No Charge after deductible	20% co-insurance after deductible	---none---
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	20% co-insurance after deductible	Imaging subject to preauthorization.
If you need drugs to treat your illness or condition For more information about prescription drug coverage, go to www.messa.org .	Generic or prescribed over-the-counter drugs	\$10 co-pay after deductible for retail 34-day supply; \$20 co-pay after deductible for retail and mail order 90 day supply.	\$10 Co-pay plus an additional 25% of BCBSM approved amount for the drug.	For information on women's contraceptive coverage, go to www.messa.org . Mail order drugs are not covered out-of-network.
	Preferred brand-name drugs	\$40 co-pay after deductible for retail 34-day supply; \$80 co-pay after deductible for retail and mail order 90 day supply.	\$40 Co-pay plus an additional 25% of BCBSM approved amount for the drug.	
	Non-Preferred brand-name drugs	\$40 co-pay after deductible for retail 34-day supply; \$80 co-pay after deductible for retail and mail order 90	\$40 Co-pay plus an additional 25% of BCBSM approved amount for the drug.	

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
		day supply.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible	20% co-insurance after deductible	---none---
	Physician/surgeon fees	No Charge after deductible	20% co-insurance after deductible	---none---
If you need immediate medical attention	Emergency room services	No Charge after deductible	No Charge after deductible	Co-pay waived if admitted.
	Emergency medical transportation	No Charge after deductible	No Charge after deductible	---none---
	Urgent care	No Charge after deductible	20% co-insurance after deductible	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	20% co-insurance after deductible	---none---
	Physician/surgeon fee	No Charge after deductible	20% co-insurance after deductible	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge after deductible	20% co-insurance after deductible	---none---
	Mental/Behavioral health inpatient services	No Charge after deductible	20% co-insurance after deductible	---none---
	Substance use disorder outpatient services	No Charge after deductible	20% co-insurance after deductible	---none---
	Substance use disorder inpatient services	No Charge after deductible	20% co-insurance after deductible	---none---
If you are pregnant	Prenatal and postnatal care	Prenatal: No Charge Postnatal: No Charge after deductible	20% co-insurance after deductible	---none---

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
	Delivery and all inpatient services	No Charge after deductible	20% co-insurance after deductible	---none---
If you need help recovering or have other special health needs	Home health care	No Charge after deductible	No Charge after deductible	---none---
	Rehabilitation services	No Charge after deductible	20% co-insurance after deductible	Physical, Occupational, Speech therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	No Charge after deductible	20% co-insurance after deductible	Applied behavioral analysis (ABA) treatment for Autism – when rendered by an approved board-certified analyst - is covered through age 18, subject to preauthorization.
	Skilled nursing care	No Charge after deductible	No Charge after deductible	Limited to a maximum of 120 days per member per calendar year.
	Durable medical equipment	No Charge after deductible	No Charge after deductible	---none---
	Hospice service	No Charge after deductible	No Charge after deductible	---none---
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	---none---
	Glasses	Not Covered	Not Covered	---none---
	Dental check-up	Not Covered	Not Covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See www.messa.org
- Hearing aids
- 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, co-payments, or co-insurance, or benefits not otherwise covered.
- Infertility treatment
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan by calling MESSA at 800-336-0013. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact MESSA Legal and Compliance by calling 1-800-742-2328. Or, you can contact Michigan Office of Financial and Insurance Regulation at www.michigan.gov/ofir or 1-877-999-6442. For group health coverage subject to ERISA, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides. (**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

4 Ever Life Insurance Company is the underwriter of this plan or selected benefits within this plan. Blue Cross Blue Shield of Michigan does not underwrite or assume any financial risk with respect to the claims liability associated with any 4 Ever Life underwritten health care products, as BCBSM is an administrator for 4 Ever Life products. 4 Ever Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association, is a wholly owned subsidiary of BCS Financial Corporation.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much insurance protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Please note: Coverage Examples are calculated based on individual coverage and calculations may not include coinsurance maximums.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,370
- You pay \$2,170

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$2,000
Co-pays	\$20
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$2,170

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,030
- You pay \$2,370

Sample care costs:

Prescriptions	\$2,900
Medical Equipment & Supplies	\$1,300
Office Visits & Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$2,000
Co-pays	\$290
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$2,370

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

MESSA ABC Plan 2

Medical plan highlights



1475 Kendale Blvd. PO Box 2560
 East Lansing, Michigan 48826-2560
 517.332.2581 • 800.292.4910

MESSA Account: Utica Community Schools

Effective Date: 5/1/2019

Employee Group: Administrators & Teachers

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 percent of the cost or the applicable out-of-network cost share amounts. For complete coverage details, go to messa.org to log in to your member account or call the MESSA Member Service Center at 800.336.0013 or TTY 888.445.5614.

Plan features	In-network
<p>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.</p>	<p>Single coverage: \$2,000 2-Person & Family coverage: \$4,000 <i>*When two or more lives are covered under this plan, the entire family deductible must be met before claims are paid for any individual.</i></p>
<p>Medical coinsurance A fixed percentage you pay for a medical service.</p>	<p>0%</p>
<p>Prescription drug coverage Under federal law governing HSA-qualified 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. <i>See Free preventive prescriptions below.</i></p>	<p>ABC Rx</p>
<p>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.</p>	<p>Single coverage: \$3,000 2-Person & Family coverage: \$6,000</p>
<p>In-network services covered at no cost to you</p>	
<p>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.</p>	
<p>Preventive care and prenatal care Certain services such as annual exams, screenings, childhood and adult immunizations, certain preventive medications and prenatal doctor visits.</p>	

In-network services subject to deductible and applicable coinsurance

Blue Cross online visit	Urgent care
Office visit	Hospital emergency room (ER)
Chiropractic services including modalities Up to 38 visits per calendar year.	Osteopathic manipulations Performed by an Osteopathic physician. Up to 38 visits per calendar year.
Inpatient hospital	Autism - applied behavior analysis (ABA) services
Outpatient physical, occupational and speech therapy Up to a combined benefit maximum of 60 visits per individual per calendar year.	Hearing aids There is a maximum benefit, adjusted annually based on the Consumer Price Index (CPI), 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.	Acupuncture Must be performed by an M.D. or D.O.
Diagnostic lab and X-ray	Radiation and chemotherapy
Allergy testing and therapy	Bariatric surgery
Mental health and substance abuse - inpatient and outpatient care	Ambulance
Medical supplies	Durable medical equipment (DME)
Prosthetics and orthotics	Home health care
Skilled nursing facility Up to a maximum of 120 days per calendar year.	Human organ transplant Must be performed at an approved facility.

Home delivery of prescription medications

MESSA members can save time and money by ordering prescription medications through the Express Scripts mail order pharmacy. If your coverage includes a mandatory mail prescription rider, you must obtain most long-term maintenance medications from Express Scripts. For more information, go to messa.org to log in to your member account and link to the Express Scripts 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 Express Scripts 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.

AD&D terminates at age 65 or when employment ends, whichever comes later.

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
Teachers without Other Dental Plan Coverage

Group #9210

Please note that 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	\$UCR per eligible individual 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 1 st permanent molar to age 9 and 2 nd 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%

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

**Porcelain and ceramic not covered for posterior teeth, alternate benefit applies

COB – Not Allowed

**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. 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.**

****This plan is intended to duplicate the benefits under the current MESSA dental plan. Any services not listed herein will be paid in the same manner in which they were under that plan**



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 Southfield, MI 48037
 248-901-3705

UTICA COMMUNITY SCHOOLS Dental Benefits Plan
Teachers with Other Dental Plan Coverage

Group #9210

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	\$UCR per eligible individual 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
Space Maintainers	Once per area per lifetime, up to age 14

Class II Restorative Services – 50%

Bitewing X-Rays	Once per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 60 months
All Other X-Rays	
Sealant Application	Once per 1 st permanent molar to age 9 and 2 nd 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%

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 – Standard

**Porcelain and ceramic 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. 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.**

****This plan is intended to duplicate the benefits under the current MESSA dental plan. Any services not listed herein will be paid in the same manner in which they were under that plan**

VSP-2 S Benefits



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 www.messa.org or www.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 www.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 examination)		
■ Elective lenses to improve vision	\$110 allowance	\$90
■ Medically necessary – to correct <i>keratoconus, irregular astigmatism, irregular corneal curvature or vision to 20/70 in the better eye</i>	MESSA pays 100% of the approved amount	\$175
Eyeglass frames		
	\$130 allowance	\$44
Eyeglass lenses		
■ Single vision		\$29
■ Bifocal	\$18 copayment	\$51
■ Trifocal		\$63
■ Lenticular		\$75
Eyeglass lens enhancements		
■ Rimless		
■ Oversized	MESSA pays 100% of the approved amount	Member must pay the difference between the approved amount and the provider charge
■ Blended		
■ Photochromic		
■ Progressive	Not covered	
■ Tinted		
● Single vision		\$33
● Bifocal		\$61
● Trifocal		\$75
● Lenticular	MESSA pays 100% of the approved amount	\$89
■ Polarized		
● Single vision		\$47
● Bifocal		\$81
● Trifocal		\$101
● Lenticular		\$119

MESSA Group Term Life Insurance Benefit Highlights

Underwritten by Life Insurance Company of North America



Good health. Good business. Great schools.

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www.messa.org

Effective Date: 07/01/2019

MESSA Account: Utica Community Schools

Employee Group: 933Q Teachers Health Professiona PAK A

*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.*

Feature	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 Benefit Highlights

Underwritten by Life Insurance Company of North America



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Employee Group: 933Q Teachers Health Professiona PAK B

*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.*

Feature	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



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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.

Feature	Definition	Your Coverage
Pre-Existing Conditions Waived	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.	Yes
Waiting Period	<i>Calendar Day (CD):</i> The waiting period is based on actual calendar days. <i>Work Day (WD):</i> The waiting period is based on the consecutive number of contracted work days. <i>Modified Fill (MF):</i> Benefits begin on the latter of exhaustion of sick time/ bank or the specified number of calendar/work day waiting period. <i>Straight Wait (SW):</i> 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.	\$3,000
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	<i>Primary:</i> Social security retirement and social security disability are offsets. <i>Family:</i> 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