2021 BENEFITS GUIDEBOOK Teachers

A Complete Benefits Package for Your Complete Life.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Lorie Briarton, Health Benefits Coordinator email LBriarton@troy.k12.mi.us ph 248.823.4006

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The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Troy School District	4. Employer Identification Number (EIN) 38-6003099	
5. Employer address 4400 Livernois	6. Employer phone number 248.823.4000	
7. City Troy	8. State MI	9. ZIP code 48098
10. Who can we contact about employee health coverage at this job? Lorie Briarton, Health Benefits Coordinator		
11. Phone number (if different from above) 248.823.4006	12. Email address LBriarton@troy.k12.mi.us	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

All employees hired by the district working 30 or more hours per week

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouse, legal dependents including children

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Welcome Introduction

Welcome!

Enclosed you will find information on your 2021 benefit package. You have 30 days after your start date, or following a qualifying event, to complete your MESSA online enrollment and return the appropriate forms. After the 30 days, you will have to wait until the next open enrollment period to make changes to your coverage. Your election will be effective based on the date in your collective bargaining agreement or employment agreement. Going forward, the regular Open Enrollment for benefits is in the Fall with a January 1st effective date.

Please contact the Benefits Office at 248-823-4006 with any questions.

Premium Conversion

To help minimize your employee contribution for your medical plan, Troy School District will continue to offer an IRC (Internal Revenue Code) Section 125 Premium Conversion Plan. This allows you to pay for your coverage on a pre-tax (before tax) basis. As a result, your net take home pay will be higher than if contributions were deducted on a post-tax (after tax) basis.

Contributions taken on a pre-tax basis are not subject to federal or state income taxes or FICA taxes. The amount of savings depends on your individual contribution and tax bracket. Your Enrollment Election will be locked in until the next open enrollment. The next open enrollment period will be in the fall for a January 1 effective date. Election changes are only allowed if you experience a mid-year qualifying event.

Inside this Issue.....

Medical/Prescription Plans

Troy School District will offer five MESSA medical plan options for you to select. You have the option between a traditional PPO and four high deductible health plans which qualify for a Health Savings Account (HSA)

Adult dependent children will lose medical coverage at the end of the calendar year (Dec 31) in which they turn age 26 unless they meet qualifying parameters as set forth by MESSA. Contact MESSA at 800.336.0013 for information.

MESSA	CHOICES PAK A		ABC 1 Pak C		ABC 2 Pak D		ABC 1– 10% Coinsurance - Pak E		ABC 2– 20% Coinsurance - Pak F	
Plan Basics	**In-Net**	**Out-Net**	**In-Net**	**Out-Net**	**In-Net**	**Out-Net**	**In-Net**	**Out-Net**	**In-Net**	**Out-Net**
Individual Deductible	$500	$1,000	$1,400	$2,800	$2,000	$4,000	$1,400	$2,800	$2,000	$4,000
Family Deductible	$1,000	$2,000	$2,800	$5,600	$4,000	$8,000	$2,800	$5,600	$4,000	$8,000
Single/ Family Out-of-Pocket*	$2,500/ $5,000	$3,000/ $6,000	$2,400/ $4,800	$4,800/ $9,600	$3,000/ $6,000	$6,000/ $12,000	$3,400/ $6,800	$6,800/ $13,600	$4,000/ $7,000	$8,000/ $16,000
*** Annual out-of-pocket maximums** – applies to deductibles, copays and co-insurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if applicable										
Other Plan Details										
Hospital Services	100% after deductible	80% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Emergency Care *(waived if admitted)*	$50 Copay		100% after deductible	80% after deductible	100% after deductible	80% after deductible	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Office Visits	$20 Copay	70% after deductible	100% after deductible	80% after deductible	100% after deductible	80% after deductible	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Prescription Drugs (assumes In-Network)										
Generic	$10 Copay		$10 Copay after deductible							
Brand	$40 Copay		$40 Copay after deductible							
Mail Order Prescriptions *(90 Days)*	MOPD 2x Copay						Mandatory Mail for Maintenance Scripts		MOPD 2x Copay	

The above is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on MESSA'a approved amount, less any applicable deductible and/or copay. Please refer to your MESSA benefit summaries on the following pages for additional information.

*The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract.
**A deductible is the amount you pay for health care services before your health insurance begins to pay.
**Coinsurance is your share of the costs of a health care service. It's usually figured as a percentage of the amount we allow to be charged for services. You start paying coinsurance after you've paid your plan's deductible.
**A copay is a fixed amount you pay for a health care service, usually when you receive the service. The amount can vary by the type of service. You may also have a copay when you get a prescription filled.

Medical Insurance Eligibility for Dependents between the ages of 19 and 26: Dependent is related to the subscriber by blood, marriage or legal adoption. Coverage automatically terminates at the end of the year in which the dependent reaches age 26. Employee may terminate coverage at annual open enrollment or at the end of the month in which dependent is covered by alternate insurance. Proof of alternate coverage, such as a letter from their employer, is required to terminate coverage at any time other than open enrollment.

Free or Low Cost Prescription Drugs

One of the most important benefits offered to our employees and their dependents is a comprehensive prescription drug plan that includes coverage for generic and brand-name drugs. We want to make employees and their dependents aware of some programs outside of the program that may save you money if you purchase certain prescription drugs.

You can use www.MichiganDrugPrices.com as a guide to compare local pharmacy prices on 150 of the most commonly prescribed prescription drugs. In addition, several of the nation's largest retailers and pharmacies now offer discounted pricing on a large range of generic equivalents and brand name prescription drugs. Drug discount cards, retail drug discount programs, and other programs may offer substantial savings from retail prices.

The following is a summary of the programs currently available.

Wal-Mart and Sam's Club*
Wal-Mart (and its subsidiary company, Sam's Club) was the first major retailer to announce it would provide a 30-day supply of approximately 300 generic drugs for $4 per prescription. This program was first rolled out in Florida, but is now being offered in more than 25 other states. A list of the medications that are available for $4 is posted on their website. This list may change over time so customers should check with the Wal-Mart pharmacist to determine if their medications are included in the discount program. To locate a participating pharmacy and to get additional details you can visit their website at www.walmart.com or www.samsclub.com.

Meijer (Michigan only)*
Meijer is offering to provide 7 commonly prescribed antibiotics and 5 leading brands of pre-natal vitamins, for free. All Meijer stores are providing the following drugs at no cost, regardless of whether the customer has insurance: Amoxicillin, Cephalexin, SMZ-TMP, Ciprofloxacin, Ampicillin, Penicillin VK and Erythromycin. You can ask your local store for information about covered drugs or visit their website at www.meijer.com.

Kmart*
Kmart now has over 100 generic medications for only $5, over 200 generic maintenance medications at $10 and an additional 100 generic maintenance medications at $15. This program is available at all Kmart stores throughout the country. A list of the medications eligible for discount pricing is posted on their website, but is subject to change. Customers should ask at their local stores for details about covered medications. You can ask your local store for information about covered drugs or visit their website at www.kmart.com.

Kroger*
Kroger now offers a *30 day supply* of over 300 generic drugs for $4 or a 90 day supply for $10 at their pharmacies. To locate a participating pharmacy and to get additional details you can visit their website at www.kroger.com/generic.

*Programs are subject to change at any time.

NOTE: We encourage you to discuss with the pharmacist any other medica ons you are taking as some an bio cs may cause interac ons.

You do not need to present your ID card to take advantage of these special pricing promotions. Only a valid prescription is necessary. NOTE: We encourage you to discuss with your doctor or the pharmacist any other medications you are taking as some antibiotics or other medications may cause serious drug interactions.

Other retailers may begin to offer similar programs in response to these initiatives, so be sure to ask your pharmacist about available discount programs when filling a prescription – it could save you money!

Programs are subject to change at any time. Troy School District does not endorse any of the above programs. This is for informational purposes only.

Employee Contributions

Premium Conversion To help minimize your employee contribution for your medical plan, Troy School District will continue to offer an IRC (Internal Revenue Code) Section 125 Premium Conversion Plan. This allows you to pay for your employee contribution for the medical coverage on a pre-tax (before tax) basis. As a result, your net take home pay will be higher than if contributions were deducted on a post-tax (after tax) basis. Contributions taken on a pre-tax basis are not subject to federal or state income taxes or FICA taxes. The amount of savings depends on your individual contribution and tax bracket.

Healthcare Premiums for the January 1, 2021 to December 31, 2021 Plan Year The chart below includes the contribu-tions and plans available to you. Those employees electing medical coverage are eligible to have any monies deducted towards the cost of health insurance coverage at the following rates withheld on a pre-tax basis. Figures listed are subject to change if there is a change to the cost of insurance. Amounts paid by Troy School District are limited by PA 152; employee is responsible for any amounts above limits set by PA 152.

FTE 1.00

PLAN	COVERAGE TIER	PER PAY 21 PAYS	Your Annual Premium Cost
Choices	Single	$ 64.87	1,362.35
	2-Person	$ 198.12	4,160.52
	Family	$ 204.49	4,294.34
ABC 1	Single	$ 22.05	462.95
	2-Person	$ 101.77	2,137.20
	Family	$ 84.58	1,776.26
ABC 2	Single	0.00	0.00
	2-Person	$ 50.31	1,056.48
	Family	$ 20.56	431.66
ABC 1 w-10%	Single	0.00	0.00
	2-Person	$ 36.70	770.76
	Family	$ 3.62	75.98
ABC 2 w-20%	Single	0.00	0.00
	2-Person	0.00	0.00
	Family	0.00	0.00

FTE 0.80

PLAN	COVERAGE TIER	PER PAY 21 PAYS	Your Annual Premium Cost
Choices	Single	$ 131.96	2,771.13
	2-Person	$ 338.41	7,106.71
	Family	$ 387.45	8,136.47
ABC 1	Single	$ 89.13	1,871.73
	2-Person	$ 242.07	5,083.39
	Family	$ 267.54	5,618.39
ABC 2	Single	$ 66.26	1,391.49
	2-Person	$ 190.60	4,002.67
	Family	$ 203.51	4,273.79
ABC 1 w-10%	Single	$ 60.22	1,264.53
	2-Person	$ 177.00	3,716.95
	Family	$ 186.58	3,918.11
ABC 2 w-20%	Single	$ 37.78	793.41
	2-Person	$ 126.52	2,656.99
	Family	$ 123.77	2,599.07

FTE 0.70

PLAN	COVERAGE TIER	PER PAY 21 PAYS	Your Annual Premium Cost
Choices	Single	$ 165.50	3,475.52
	2-Person	$ 408.56	8,579.81
	Family	$ 478.93	10,057.54
ABC 1	Single	$ 122.67	2,576.12
	2-Person	$ 312.21	6,556.49
	Family	$ 359.02	7,539.46
ABC 2	Single	$ 99.80	2,095.88
	2-Person	$ 260.75	5,475.77
	Family	$ 294.99	6,194.86
ABC 1 w-10%	Single	$ 93.76	1,968.92
	2-Person	$ 247.15	5,190.05
	Family	$ 278.06	5,839.18
ABC 2 w-20%	Single	$ 71.32	1,497.80
	2-Person	$ 196.67	4,130.09
	Family	$ 215.24	4,520.14

FTE 0.60

PLAN	COVERAGE TIER	PER PAY 21 PAYS	Your Annual Premium Cost
Choices	Single	$ 199.04	4,179.91
	2-Person	$ 478.71	10,052.90
	Family	$ 570.41	11,978.60
ABC 1	Single	$ 156.21	3,280.51
	2-Person	$ 382.36	8,029.58
	Family	$ 450.50	9,460.52
ABC 2	Single	$ 133.35	2,800.27
	2-Person	$ 330.90	6,948.86
	Family	$ 386.47	8,115.92
ABC 1 w-10%	Single	$ 127.30	2,673.31
	2-Person	$ 317.29	6,663.14
	Family	$ 369.54	7,760.24
ABC 2 w-20%	Single	$ 104.87	2,202.19
	2-Person	$ 266.82	5,603.18
	Family	$ 306.72	6,441.20

FTE 0.50

PLAN	COVERAGE TIER	PER PAY 21 PAYS	Your Annual Premium Cost
Choices	Single	$ 232.59	4,884.30
	2-Person	$ 548.86	11,526.00
	Family	$ 661.89	13,899.67
ABC 1	Single	$ 189.76	3,984.90
	2-Person	$ 452.51	9,502.68
	Family	$ 541.98	11,381.59
ABC 2	Single	$ 166.89	3,504.66
	2-Person	$ 401.05	8,421.96
	Family	$ 477.95	10,036.99
ABC 1 w-10%	Single	$ 160.84	3,377.70
	2-Person	$ 387.44	8,136.24
	Family	$ 461.01	9,681.31
ABC 2 w-20%	Single	$ 138.41	2,906.58
	2-Person	$ 336.97	7,076.28
	Family	$ 398.20	8,362.27

FTE 0.40

PLAN	COVERAGE TIER	PER PAY 21 PAYS	Your Annual Premium Cost
Choices	Single	$ 266.13	5,588.68
	2-Person	$ 619.00	12,999.10
	Family	$ 753.37	15,820.74
ABC 1	Single	$ 223.30	4,689.28
	2-Person	$ 522.66	10,975.78
	Family	$ 633.46	13,302.66
ABC 2	Single	$ 200.43	4,209.04
	2-Person	$ 471.19	9,895.06
	Family	$ 569.43	11,958.06
ABC 1 w-10%	Single	$ 194.38	4,082.08
	2-Person	$ 457.59	9,609.34
	Family	$ 552.49	11,602.38
ABC 2 w-20%	Single	$ 171.95	3,610.96
	2-Person	$ 407.11	8,549.38
	Family	$ 489.68	10,283.34

FTE 0.20

PLAN	COVERAGE TIER	PER PAY 21 PAYS	Your Annual Premium Cost
Choices	Single	$ 333.21	6,997.46
	2-Person	$ 759.30	15,945.29
	Family	$ 936.33	19,662.87
ABC 1	Single	$ 290.38	6,098.06
	2-Person	$ 662.95	13,921.97
	Family	$ 816.42	17,144.79
ABC 2	Single	$ 267.52	5,617.82
	2-Person	$ 611.49	12,841.25
	Family	$ 752.39	15,800.19
ABC 1 w-10%	Single	$ 261.47	5,490.86
	2-Person	$ 597.88	12,555.53
	Family	$ 735.45	15,444.51
ABC 2 w-20%	Single	$ 239.04	5,019.74
	2-Person	$ 547.41	11,495.57
	Family	$ 672.64	14,125.47

Opt-Out (cash in lieu)

If 45 or more select this option, the cash payment shall be $2,500 annually*. Must have completed the MESSA on-line enrollment to 'Waive Medical'.

*Please note: Cash In Lieu amounts are based on your current FTE. Cash in lieu payments are made the second pay in January and second pay in June.

If you have any questions regarding the Cash in Lieu, please reference your TEA Contract, or call the Benefit's Office at 248-823-4006.

Dental and Vision Coverage

The dental plan with MESSA/Delta allows employees to go to any dentist.

When you seek services from a dentist who participates with Delta Dental, the dentist will bill Delta Dental directly and your out-of-pocket costs will be limited to the deductible and the copayment for covered charges as specified in your plan. If you choose to see a non-participating dentist, you may have higher out-of-pocket costs and the dentist may not bill Delta Dental directly. You can find a participating dentist on Delta Dental's website www.deltadentalmi.com.

The benefit plan year is July through June.
However, for cleanings the benefit period is **no more than 2 cleanings in a 12-month period**.

	Delta Dental Non-Coordinated (Have no other dental coverage)	**Delta Dental Coordinated** (Also have additional dental coverage through spouse's/parent's dental plan)
Class 1		
Diagnostic and Preventive	100%	50%
Class 2		
Basic Services	90%	50%
Class 3		
Major Services	90%	50%
Class 4		
Orthodontic Services	90%	50%

Adult dependent children will lose dental and vision coverage at the end of the calendar year (Dec 31) in which they turn age 25 unless they meet qualifying parameters as set forth by MESSA. Contact MESSA at 800.336.0013 for information.

The MESSA/VSP plan is a preferred provider plan. This means, if you seek benefits from an in-network provider, you will receive deeper discounts and incur lower out of pocket costs.

You can find a participating provider on VSP's website at **www.vsp.com**. The benefit plan year is July through June.

Here is an overview of the benefits when using a participating provider. A full benefit summary is available on the district's website. Please refer to VSP Benefit Guide located in the back of this guide for specific plan details.

	VSP3 Plan
Exam	$35
Disposable Contact Lens	$115
Frame Allowance	$65

Flexible Spending Accounts (FSA)

Troy School District will continue to offer the Health Care and Dependent Care Flexible Spending Accounts (FSA's). The Health Care and Dependent Care Flexible Spending Accounts allow you to set aside pre-tax dollars from your paycheck to pay for eligible health care and/or dependent care expenses.

The FSA plan will be offered through iSolved Benefit Services - previously known as Infininsource. Employees who enroll in a MESSA ABC Plan are NOT eligible for both the Health Care FSA and the Health Savings Account. The FSA plan year will be January 1st through December 31st.

All benefit eligible employees have the ability to enroll in the Dependent Care FSA plan.

More information available at: https://isolvedbenefitservices.com and www.irs.gov

Below is a short listing of eligible expenses:

Eligible Healthcare Expenses	Eligible Dependent Healthcare Expenses
• Deductibles, Co-Insurance, Co-Pays, etc.	• Child Care (daycare / preschool)
• Routine Physical Exams	• Before/After school care
• Mental Health / Substance Abuse Services	• Day Camps
• Vision Expenses	• In-Service days (no school)
• Dental Expenses	• School Holidays / Vacation
• Over-the-Counter (OTC) Medications (if prescribed)	• Transportation

You can contribute:

- Up to **$2,750** per year to the Health Care FSA
- Up to **$5,000** per year to the Dependent Care FSA.

Important Note: *Effective, January 1, 2011 under Healthcare Reform, the definition of a qualified medical expense for purposes of FSAs will be limited to prescribed medications and insulin. Therefore, as of January 1, 2011 over the counter items will no longer be reimbursable under any Flexible Spending plan. Over the counter items include: antacids, antiseptic ointment, allergy medicine, pain relievers, stomach remedies etc. Note: Prescribed medication includes medications that are also available over the counter as long as the medication requires a prescription for the covered individual.*

Health Savings Account Overview

Health Savings Accounts (HSA)

In this guide, we have included information about Health Savings Accounts (HSA), which is available to ABC Plan participants. The next few pages provides an overview of the important requirements as well as some commonly asked questions. We encourage you to contact your tax adviser with specific HSA questions as the impact of these accounts changes based on circumstances.

There are several advantages to enrolling in an HSA.

- ◊ Contributions made to the HSA are pre-tax so your money goes further.
- ◊ Money in the HSA can also be used for dental and vision; the HSA allows you to pay for these services with pre-tax dollars. Any money spent on dental or vision does NOT count toward meeting your medical deductible
- ◊ Your HSA can be used as a tax sheltered investment.
- ◊ The prescription drug plan offered with the ABC Plan provides free maintenance drugs such as medicines for high blood pressure and cholesterol.
- ◊ After you meet your deductible, services are covered at 100%. The only copays are for some prescription medications.
- ◊ If you do not meet your deductible any money remaining in your HSA is yours to keep. It's your money!

What is an HSA?

A Health Savings Account (HSA) is a cross between a flexible spending account (FSA), an IRA, and a 401(k)/403(b). Only those who enroll in the MESSA ABC Plan have the option to participate in the HSA, if eligible. You can access your HSA to pay for eligible expenses. In addition, your account has the ability to grow, year-to-year, tax deferred. The HSA account is your property and responsibility. Like a 401(k)/403(b), it is your money and stays with you.

Eligibility

You must meet certain requirements in order to participate in the HSA Contribution feature. To be eligible, you must:

(a) Be covered by one of the MESSA ABC High Deductible Health Plans;

(b) Not be claimed as another person's tax dependent;

(c) Not be covered by Medicare; and

(d) Not have any health coverage other than coverage under a High Deductible Health Plan. Other coverage that will disqualify you from being eligible for the HSA Contribution Feature includes, but not limited to, coverage under your spouse's health plan if his/her plan is not considered a HDHP plan under IRS guidelines. Coverage under your spouse's medical expense reimbursement plan or flexible spending account, and coverage under a health reimbursement arrangement, including your spouse's health reimbursement arrangement.

Health Savings Account (Continued)

Consideration

An HSA is an employee's property and HSA account holders are responsible for ensuring they meet the eligibility requirements for the pre-tax benefit as well as ensuring the funds are used to pay for qualified medical expenses. The HSA is separate from the medical high deductible plan and is a bank account used to help pay for those expenses not covered by the plan with pre-tax dollars.

Using Your HSA

Money in your HSA can be used to pay for a variety of healthcare-related expenses for you and your IRS eligible dependents (any out of pocket medical, dental and vision coverage after the insurance plan pays or processes the claim) ranging from routine exams to prescription drugs. A full listing of eligible expenses can be found at https://irs.gov/pub/irs-pdf/p969.pdf. To pay for expenses, you simply present your HSA debit card to your provider, and money will be deducted directly from your HSA.

Please note that you are not required to submit receipts for the purchases that you make. It is your responsibility to keep the supporting records to show the Internal Revenue Service whether you used the funds to pay qualified medical expenses.

HSA Employee Funding

You will have the option to fund your account with pre-tax dollars. The Statutory Maximum HSA Contribution for the **2021** calendar year is $3,600 for a single and $7,200 for a 2 person/family. If you are age 55 or older, you can make an additional catch-up contribution amount of $1,000 in both the 2020 and 2021 calendar years. The HSA cannot receive contributions after you have enrolled in Medicare. ***You have the ability to adjust your HSA pre-tax election monthly.***

Your HSA money is tax-free as long as it is used to pay for qualified medical, dental and vision expenses. If you use the money for any other reason, you will be required to pay income tax and a 20% tax penalty on that amount (you will not pay a penalty if you are disabled or age 65 or older).

The total contributions made by you and/or made on your behalf (i.e., contributions by your Employer) into HSAs owned by you are subject to a maximum contribution limit.

If you are eligible for contributions for only a portion of the year, your maximum contribution (including catch-up contributions) is determined in accordance with the following "rules":

(a) Not Eligible on December 1st. If you cease to be eligible for contributions prior to December 1st of a particular year, the contribution limit for that year will be a fraction of the maximum contribution for the full year based upon the number of months in which you were eligible.

For Example, if you have single coverage under a qualifying High Deductible Health Plan, you are not eligible for catch up contributions, but are eligible only during January through June (i.e., six months of the year), your maximum contribution would be limited.

(b) Eligible on December 1st. If you become eligible for HSA contributions during a particular year and you are eligible as of December 1st of that year, your maximum contribution for that year is the full indexed amount. However, if you become ineligible for HSA contributions during the twelve (12) month period beginning with December of that year, you will not be entitled to the full maximum contribution. Instead, your maximum contribution will be a fraction of the maximum contribution for the full year based upon the number of months in which you were eligible during that year. The excess contributions will be included in your gross income and an additional tax will be imposed on those contributions.

Health Savings Account (Continued)

Rollover contributions may also be made to an HSA from another health savings account or from an Archer MSA. Rollover contributions are not subject to the contribution limit described above, however, exclusions do apply.

What happens if my contributions exceed the contribution limit?

If the contributions to your HSA exceed the applicable maximum contribution limit for a year, generally the excess contributions will be included in your income and an excise tax will be imposed upon them. However, you can avoid the excess tax if you take a distribution of the excess contributions (and the net income attributable to the excess contribution) before the last day (including extensions) for filing your federal income tax return. This distribution must be included as a taxable income when you file your taxes.

What are the tax consequences of the HSA Contribution Feature?

The contributions made under this HSA Contribution Feature will not be included in your gross income, unless they exceed the applicable maximum contribution limit as discussed above.

What are the rules regarding distributions from my HSA?

Your Employer has no control over or involvement with distributions made from your HSA. Your Employer does not substantiate expenses for which such distributions are made. Information regarding the procedure for obtaining distributions and the consequences of taking distributions is available from the trustee/custodian of your HSA.

When does my participation end?

Participation in the HSA Contribution Feature ends upon the earlier of the date your participation in the Plan ceases or the date you no longer satisfy the eligibility requirements of the plan. You need not be a participant in the HSA Contribution Feature (or be employed by the Employer) in order to obtain distributions from your HSA. In addition, you may make contributions to your HSA outside this Plan, provided you are eligible to do so under IRS rules, after you have left employment with the Employer or have ceased to be a participant in the Plan.

NOTE: This HSA Contribution Feature is **not** a group health plan for purposes of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), the Family and Medical Leave Act (FMLA), and the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). COBRA, FMLA, and USERRA do not apply to this HSA Contribution Feature. However, COBRA, FMLA, and USSERRA may apply to the Qualifying High Deductible Health Plan.

Can the contributions made to my HSA be forfeited?

No, once the contributions have been deposited in your HSA, you will have a nonforfeitable interest in the funds. You will be free to request a distribution of the funds or to move them to another provider of HSAs, to the extent allowed by law.

What are the reporting requirements?

Your Employer is responsible for reporting contributions made to your HSA through this HSA Contribution Feature on your Form W-2. You are also responsible for reporting contributions to your HSA, and for reporting distributions from your HSA, on appropriate forms available from the IRS.

Take Control of Your Coverage

Create online accounts at:

MESSA - (https://www.messa.org)

Benefit Plan Year: Jan 1 through Dec 31

What you can do with your account ...

*Keep track of your deductibles, maximums and copays
*View your plan coverage information booklet
*View your claims history
*Find a doctor
*See if your plan covers a prescription drug
*View your explanation of benefits (EOB)
*Take advantage of on-line health resources

MESSA
Good health. Good business. Great schools.

Michigan Education Special Services Association

Delta Dental of Michigan - (https://www.deltadentalmi.com)

Benefit Plan Year: July 1 through June 30

What you can do with your account...

*View EOB's for submitted claims
*Request ID cards
*View your plan's dental benefits

DELTA DENTAL

VSP - (https://www.vsp.com)

Benefit Plan Year: July 1 through June 30

What you can do with your account...

*Request ID Cards
*View your plan's vision benefits and claims
*Find a participating provider

vsp

HSA - Health Equity (https://my.healthequity.com)

Calendar Year: Jan 1 through Dec 31

What you can do with your account...

*View Balances
*Pay Service Providers
*Reimburse Yourself for healthcare costs

FSA - Flexible Spending (https://isolvedbenefitservices.com)

Calendar Year: Jan 1 through Dec 31

What you can do with your account...

*View Balances
*Pay Service Providers
*Reimburse Yourself for healthcare costs
*Reimburse Yourself for dependent care costs

FSA
USE IT or LOSE IT

Important Notifications

Women's Health and Cancer Rights Act of 1998 - Annual Notice

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

Newborn and Mother's Health Protection Act - Annual Notice

Group health plans and health insurance issuers generally may not, under Federal law, 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).

Special Enrollment Event/Changes In Family Status

Making Changes to Your Elections

Your benefit elections cannot be changed during the plan year unless you have a qualifying "Change in Status Event."

Change in Status Events for all Benefit Programs are any of the following events:

- You or your Eligible Dependent become eligible or ineligible for coverage on account of a change in:

  ☑ Legal marital status (for example; marriage, divorce, legal separation, annulment)*;
  ☑ Number of dependents (for example; birth, death, adoption, placement for adoption);
  ☑ You or your Eligible Dependent's employment status (for example; termination or commencement of employment, taking or returning from an unpaid leave of absence—including those protected under FMLA)
  ☑ You or your Eligible Dependent's job status (for example; part-time to full-time, or union to non-union, or vice versa);
  ☑ Residence or work site; or
  ☑ An Eligible Dependent's status.**

- A change in coverage due to an election made by your spouse or dependent during an open enrollment period under the spouse's or dependent's employer's benefit plan that relates to a period that is different from the Plan Year for this Plan. ***
- A change in the availability of benefit options or coverage (addition or removal) under the Plan's Benefit Programs.***
- A significant increase or decrease in the cost of coverage during the Plan Year. This includes an increase or decrease in your Eligible Dependent Care Expenses for a care provider who is not a relative. ***
- A change in your dependent care provider. ***(This is a Change Event for the DFSA Benefit Only.)***

Additional Change in Status Events for the Medical, Dental and HFSA Benefit Programs

In addition to the Change Events listed above, you may change your benefit elections if:

- You or your Eligible Dependent becomes eligible for COBRA Continuation Coverage or extended coverage under USERRA;
- A judgment, decree, or order, resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order), is entered by a court of competent jurisdiction that requires accident or health coverage for your child under this Plan;
- You or your Eligible Dependent becomes enrolled or loses coverage under Part A or Part B of Medicare or Medicaid (other than coverage solely with respect to the distribution of pediatric vaccines); or
- For the Medical Benefit Program only, you or your Eligible Dependent are eligible for a Special Enrollment Period.

Consistency Rule

Your election changes must be consistent with the Change in Status Event that affects your coverage under the Benefit Program. For example:

- If one of your Eligible Dependents no longer qualifies as an Eligible Dependent, you could cancel coverage for that dependent, but you could not cancel coverage for your other Eligible Dependents; or
- If you have single coverage and you marry, you may elect two person or family coverage, whichever applies.

*You must provide proof of a change in your legal marital status to the Employee Services Department.
**You must provide proof of a change in an Eligible Dependent's status to the Employee Services Department.
*** This is <u>not</u> a change Event for the HFSA or DFSA Benefit Programs.

Special Enrollment Event/Changes In Family Status

Some of the Change of Events may allow you the option of either adding or removing coverage. For example, your spouse changing an election under his or her employer's plan may allow you to add or remove coverage under this Plan, so long as your choice is consistent with your spouse's election.

You must report any status change to the Employee Services Department within **30 days** of the date of the event. Otherwise, you will be required to wait until the next open enrollment to enroll them.

It is your responsibility to notify the Employee Services Department within **30 days** if you have a dependent that is no longer eligible. Those dependents may have continuation rights for medical coverage under the federal law known as COBRA. If you do not notify the Employee Services Department within the required time frame, those dependents could be left with no insurance coverage under our plan.

Special Enrollment

You may qualify for a special enrollment if certain events occur in your life:

- If you decline coverage for yourself and/or your dependents (including your spouse) because you are covered under another health plan, you may, in the future, be able to enroll yourself and/or your dependents in the plan if you experience an involuntary loss of that coverage (e.g., spouse loses his/her job, divorce).

- 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 in the plan.

In either situation, you must request enrollment through the Employee Services Department **within 30 days** after the special enrollment event as described above. If you enroll as the result of a special enrollment event, coverage will be made effective on this date of the event.

INFINISOURCE
is NOW:
iSOLVED BENEFIT SERVICES
same company--name change only

Flexible Spending Account Election Form

2021 Calendar Year (1/1/2021 – 12/31/2021)

Indicate your TSD Pay Schedule

___21 Pay Schedule ___26 Pay Schedule

SECTION 1: Employee Contact information

EMPLOYEE LAST NAME | FIRST NAME / M.I. | LAST 4 DIGITS OF SOC SEC# | EMPLOYEE ID #

Troy School District

EMPLOYER | DAYTIME PHONE # | EMAIL ADDRESS | Check if new

Check if new | STREET ADDRESS | CITY | STATE | ZIP

SECTION 2: Election Information

Employee contributions may only be made based upon the pay schedule indicated above; FSA/DCA Accounts may not be pre-funded

Health Care Reimbursement Plan

O I elect to participate.

$_____ is my PRE-TAX annual election

Cannot exceed $2,750 annually

O I elect NOT to participate.

Dependent Care Reimbursement Plan

O I elect to participate.

$_____ is my PRE-TAX annual election. *Cannot exceed $5,000 annually or $2,500 for an employee who is married and filing a separate tax return).*

O I elect NOT to participate.

By signing this form, I understand that I am authorizing funds to be taken from my paycheck on a PRE-TAX basis and transferred into my Flexible Spending Account based on the Pay Schedule indicated above. The amount that I am requesting to be deducted will reduce my annual taxable wages.

I understand that my election into the Health Care and the Dependent Care Plan(s) cannot be changed during the plan year unless I experience a qualifying change in status.

X

EMPLOYEE SIGNATURE VERIFICATION **DATE**

* Return this enrollment form to your employer benefits department

Infinisource, Inc. has incorporated the HIPAA Privacy Requirements to reflect our organization's business practices regarding your FSA coverage.

15 E. Washington St • PO Box 488 • Coldwater, MI 49036-0488 • 866.370.3040 • Fax: 800.379.5670 • E-mail: fsa@isolvedhcm.com

Important Information Regarding Your Flexible Spending Account(s) and Open Enrollment

1/1/2021 - 12/31/2021 Plan Year

The 2020 Flexible Spending Account (FSA) plan year is quickly coming to a close. If you wish to participate in the 2021 plan year, please complete the enclosed enrollment form and return it by the end of open enrollment. Below you will find some reminders about the current plan year, and the upcoming open enrollment period and new plan year.

Your FSA will be administered by iSolved Benefit Services. Previously known as Infinisource - name change only.

2020 Plan Year (1/1/2020 – 12/31/2020):

• **Plan Year –** The plan year ends on December 31st, 2020; therefore all eligible expenses must be incurred on or before 12/31/2020 in order to be eligible for reimbursement from the 2020 plan year.
• **Run Out Period** – You have 60 days, or until February 28, 2021 to submit reimbursement claims for those expenses that incurred during the 2020 plan year.
• **Remaining Balance** – If you wish to determine the balance remaining in your FSA account(s) login to iSolved Benefit Services online system to verify this information or download their Mobile App for Android, iPhone, or iPad devices. Remember that your FSA is a tax- free benefit; therefore you must use your remaining balance before the end of the plan year to avoid forfeiting the remaining balance.
• **Termination Run Out** – Should you terminate employment, you have 30 days from the date you terminate to submit claims incurred prior to your termination date.

2021 Plan Year (1/1/2021 – 12/31/2021):

Open Enrollment – Included with this letter is your FSA enrollment form for the upcoming plan year. All elections must be completed no later than the end of open enrollment.

Types of Accounts available through this plan:

• **Health Care FSA Maximum Election** – $2,750.00
• **Dependent Care FSA Maximum Election** – $5,000.00

Features of this plan:

• **Payroll Deductions** – Deductions for health and dependent care will begin with the first paycheck following the beginning of the new plan year.
• **Direct Deposit** – If you would like to have manual claim reimbursements directly deposited into your bank account, please contact iSolved Benefit Services at 866-370-3040.
• **Debit Card** – First time FSA enrollees, you will receive a new debit card from iSolved Benefit Services prior to 1/1/2021 for your health FSA. Effective 1/1/2021 it will be loaded with your 2021 annual election. Please be aware that you must retain copies of the receipts from your debit card purchases. Throughout the year you may be asked to provide a copy of your receipt to substantiate your debit card purchases.

Did You Know?

• **iFLEX Mobile App** – allows access to your account balance. See how much you have to spend on qualified health or dependent care expenses at time of purchase. Also, submit claims for reimbursement and upload receipts using the camera on your mobile device.

If you need assistance with your FSA please call iSolved Benefit Services at 866-370-3040. To find resources, answers to questions, and lists of qualified expenses, visit the iSolved Benefit Services FSA Resource Center at www.isolvedbenefitservices.com

2021 Health Savings Account (HSA) Contribution Action Request Form

Complete this form to make changes to your Health Savings Account contribution amount. This form is available to be completed on FrontLine Central, or return completed form to Troy School District, Employee Services, ATTN: Lorie Briarton, 4400 Livernois, Troy MI 48098, or scan and email to LBriarton@troy.k12.mi.us or fax to 248-823-4013.

Employee Information

Employee Name: _____ Emp. ID No: _____

Indicate Your Medical Coverage Level

☐ Employee ☐ *Family

Indicate Your Pay Cycle

☐ 21 - pay ☐ 26 - pay

Family coverage includes Employee w/ Spouse, Employee w/ Child(ren), and being enrolled in a 2-Person or Family High Deductible Health Plan (HDHP). Employees enrolled in the MESSA Choices or the BCBS CB2, CB3 or CB4 plans are **NOT ELIGIBLE to contribute to a HSA.*

2021 Contribution Information

You may not reduce your annual amount below what you have contributed-to-date, as refunds are not an option. The annual contribution must be an amount not to exceed your applicable maximum limit as described below.

Maximum Annual Contribution (Under age 55)

- Employee-only HSA.....$3,600
- Family HSA*.....$7,200

Maximum Annual Contribution (Age 55+)

- Employee-only HSA.....$4,600
- Family HSA*.....$8,200

If you retire during this calendar year, your maximum contribution **may not exceed** the above applicable maximum, ÷ 12 months, multiplied by the total number of full months you are planning to work, **Example--if retiring at the end of the school year, are over the age of 55 and are enrolled in a high-deductible plan with Family coverage: $7200 PLUS the full $1,000 for catch up = $8200 ÷ 12 months x 6 months (Jan-June) = $4,100. Your 2021 HSA annual maximum contribution may NOT exceed $4,100**. The same calculation would be used when you've turned 65 **and** enrolled in Medicare Part A or B; you lose HSA eligibility as of the first day of the month in which you enrolled in Medicare Part A or B and may not contribute for that month forward. *Annual Contributions that exceed your applicable maximum will result in an IRS Penalty as well as being taxed. For more HSA information go to the IRS Link at:* **https://www.irs.gov.**

If you do not indicate an annual maximum amount below, it is your responsibility to monitor your annual contribution amount; the District does not monitor your annual contribution amount if no Annual Maximum is indicated.

Action Request * A **new** Action Form must be completed each time you request to change your HSA deduction—no exceptions *

Your Action Date * Payroll vouchers are run on Wednesdays prior to the actual pay day – **Select your dates carefully** *

If you are just beginning your HSA:

☐ **START** Health Savings Account Contributions

Begin my HSA deduction on (DATE): _____ Per Pay Amount $ _____

Set my ANNUAL Maximum Contribution **NOT TO EXCEED** $ _____

If you are changing your current HSA deduction amount and/or annual maximum:

☐ **CHANGE** Health Savings Account Contributions

Please use the 2nd change line when you want the 1st change line to only be for 1 or 2 pay dates – for example: Off-Schedule Payments

1) Change my HSA deduction **on** (DATE): _____ **NEW** Per Pay Amt $ _____

Set my ANNUAL Maximum Contribution **NOT TO EXCEED** $ _____

2) Change my HSA deduction **on** (DATE): _____ **NEW** Per Pay Amt $ _____

Set my ANNUAL Maximum Contribution **NOT TO EXCEED** $ _____

If you no longer want to make HSA contributions:

☐ **STOP** Health Savings Account Contributions

Stop my HSA contribution deduction **on** (DATE): _____

To assure we meet your desired Action DATE, Action Requests should be submitted 10 days prior your Action Request DATE

Employee Authorization

I authorize TSD to withhold my contributions on a pre-tax basis from my pay for this plan. I understand the amount I am requesting to be deducted for this plan will reduce my annual taxable wages.

_____ _____

SIGNATURE *DATE*

Guidelines for Designation of Beneficiaries

General - Please be sure to include the beneficiary's full name, social security number and relationship to you. Providing this information can help expedite the claim process by making it easier to locate and verify beneficiaries.

Minors - While you may designate minors as beneficiaries, please note that claim payments may be delayed due to special issues raised by these designations. In the event of a claim and the beneficiary is a minor child, the insurance proceeds will not be released to the minor child. The insurance proceeds may be paid to a duly appointed guardian of the child's estate. You may want to obtain the assistance of an attorney in drafting your beneficiary designation.

Trust as Beneficiary - You may designate a trust as beneficiary, using the following form: "To [name of trustee], trustee of the [name of trust], under a trust agreement dated [date of trust]."

If you wish to designate a testamentary trust as beneficiary (i.e., one created by will), you should recognize the possibility that your will which was intended to create this trust may not be admitted to probate (because it is lost, contested, or superseded by a later will). Claim payment delays can result if the beneficiary designation doesn't provide for this situation.

Life Status Changes - We recommend that you review your beneficiary designation when significant life status events occur, such as marriage, divorce, or birth of a child.

See an Attorney! The above guidelines are general and are not intended to be relied on as legal advice. Unless your designation is a simple one, we recommend that you obtain the assistance of an attorney in drafting your beneficiary designation. A qualified attorney can help assure that your beneficiary designation correctly reflects your intentions, is clear and unambiguous, and meets legal requirements.

VSP-3 Benefits

Benefit Plan Year: July 1 through June 30

MESSA.
Good health. Good business. Great schools.

In-network providers

Most eye doctors are in VSP's Signature network. Staying in-network assures that 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 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	No copayment	$35
– Ophthalmologist		$45
Contacts (includes lenses, examination and fitting)		
– Elective lenses to improve vision	$115 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	$65 allowance	$55
Eyeglass lenses		
– Single vision	MESSA pays 100% of the approved amount	$38
– Bifocal		$60
– Trifocal		$72
– Lenticular		$108
Eyeglass lens enhancements		
– Rimless	MESSA pays 100% of the approved amount	Member must pay the difference between the approved amount and the provider charge
– Oversized		
– Blended		
– Photochromic		
– Progressive	Not covered (discounts may apply)	Not covered
– Tinted		
• Single vision	MESSA pays 100% of the approved amount	$42
• Bifocal		$70
• Trifocal		$84
• Lenticular		$118
– Polarized		
• Single vision		$56
• Bifocal		$90
• Trifocal		$110
• Lenticular		$138

FS Rev. 08/30/17 Pr. 8/17 - IPOF

Ulliance

Enhancing People. Improving Business.

No cost and completely confidential

LIFE ADVISOR EAP®

The Ulliance Life Advisor EAP® is a benefit that employers can sponsor and offer total well-being services to their employees, spouse/live-in partner and dependents under the age of 27 at no cost to the employee.

Counseling

Counseling is available in-person or telephonically with a counselor close to work, home or school. Individual, family and couples counseling are all included. Short-term, solution focused support for work-life issues such as stress, major life transitions, relationship issues, substance use, grief/loss and overwhelming emotions.

Coaching

Life Advisor Coaches offer telephonic support for individual life enhancement goals, such as education, career advancement, financial or self improvement goals.

Crisis Support

Mental health professionals are available by phone 24/7/365.

Referrals

Consultants provide recommendations for resources within the community.

Work-life Materials

Information on a wide range of work-life balance topics are easily accessed through the EAP portal. A work-life library of related books are available by calling Ulliance and as always, are free of charge.

Legal & Financial Consultations

Ulliance professionals can connect employees with resources to assist individuals regarding legal and financial issues.

Connect with us 800.448.8326 LifeAdvisorEAP.com

Blue Cross Blue Shield of Michigan

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

MESSA Choices

Saver Rx

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?	$500 Individual/ $1,000 Family	$1,000 Individual/ $2,000 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
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)	$1,500 Individual/ $3,000 Family	$3,000 Individual/ $6,000 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been 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	$20 copay/office visit	20% coinsurance	None
	Specialist visit	$20 copay/office visit	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 preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.messa.org	Generic or prescribed over-the-counter drugs	$10 copay/prescription for retail 34-day supply; $20 copay/prescription for retail and mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	Preventive drugs covered in full. Your prescription drug coverage has a separate out-of-pocket limit of $1,000/$2,000. Mail order drugs are not covered out-of-network.
	Preferred brand-name drugs	$40 copay/prescription for retail 34-day supply; $80 copay/prescription for retail and mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
	Non-preferred brand-name drugs	$40 copay/prescription for retail 34-day supply; $80 copay/prescription for retail and mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
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	$50 copay/visit	$50 copay/visit	Copay waived if admitted or for an accidental injury.
	Emergency medical transportation	No Charge	No Charge	Mileage limits apply
	Urgent care	$25 copay/visit	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% coinsurance	Preauthorization 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	Preauthorization 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
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	20% coinsurance	Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization.
	Skilled nursing care	No Charge	No Charge	Physician certification required. Limited to 120 days per member per calendar year

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)	
	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**

Blue Cross Blue Shield of Michigan

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

MESSA ABC & ABC Rx

Plan 1

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?	$1,400 Individual/ $2,800 Family	$2,800 Individual/ $5,600 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)	$2,400 Individual/ $4,800 Family	$4,800 Individual/ $9,600 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	None
	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 preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.messa.org	Generic or prescribed over-the-counter drugs	$10 copay/prescription for retail 34-day supply; $20 copay/prescription for retail and mail order 90-day supply	In-Network copay plus an additional 25% of the approved amount	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; $80 copay/prescription for retail and mail order 90-day supply	In-Network copay plus an additional 25% of the approved amount	
	Non-preferred brand-name drugs	$40 copay/prescription for retail 34-day supply; $80 copay/prescription for retail and 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
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

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 have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% coinsurance	Preauthorization 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	Preauthorization 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
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	20% coinsurance	Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization.
	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	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	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)	
For more information on pediatric vision or dental, contact your plan administrator	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**

Blue Cross Blue Shield of Michigan

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

MESSA ABC & ABC 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)	$3,000 Individual/ $6,000 Family	$6,000 Individual/ $12,000 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	None
	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 preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.messa.org	Generic or prescribed over-the-counter drugs	$10 copay/prescription for retail 34-day supply; $20 copay/prescription for retail and mail order 90-day supply	In-Network copay plus an additional 25% of the approved amount	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; $80 copay/prescription for retail and mail order 90-day supply	In-Network copay plus an additional 25% of the approved amount	
	Non-preferred brand-name drugs	$40 copay/prescription for retail 34-day supply; $80 copay/prescription for retail and 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
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

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 have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% coinsurance	Preauthorization 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	Preauthorization 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
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.
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	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	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	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)	
For more information on pediatric vision or dental, contact your plan administrator	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
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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.

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Language Access Services: **See Addendum**

Blue Cross Blue Shield of Michigan

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

MESSA ABC & ABC Rx

Plan 1 Coins 10% w/Mandatory Mail

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?	$1,400 Individual/ $2,800 Family	$2,800 Individual/ $5,600 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)	$3,400 Individual/ $6,800 Family	$6,800 Individual/ $13,600 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,deductible, 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	10% coinsurance	30% coinsurance	None
	Specialist visit	10% coinsurance	30% 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)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	May require preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.messa.org	Generic or prescribed over-the-counter drugs	$10 copay/prescription for retail 34-day supply; $20 copay/prescription for mail order 90 day supply	In-Network copay plus an additional 25% of the approved amount	Preventive drugs covered in full. A 90-day supply of prescription drugs is not payable at a retail pharmacy. A 90-day supply is only payable at a participating mail order pharmacy. Mail order drugs are not covered out-of-network.
	Preferred brand-name drugs	$40 copay/prescription for retail 34-day supply; $80 copay/prescription for mail order 90 day supply	In-Network copay plus an additional 25% of the approved amount	
	Non-preferred brand-name drugs	$40 copay/prescription for retail 34-day supply; $80 copay/prescription for 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)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	Mileage limits apply
	Urgent care	10% coinsurance	30% 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 have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization is required
	Physician/surgeon fee	10% coinsurance	30% coinsurance	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	10% coinsurance	30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	No Charge; deductible does not apply	30% 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	10% coinsurance	30% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	Physician certification required.
	Rehabilitation services	10% coinsurance	30% coinsurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	10% coinsurance	30% coinsurance	Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization.
	Skilled nursing care	10% coinsurance	10% coinsurance	Physician certification required. Limited to 120 days per member per calendar year
	Durable medical equipment	10% coinsurance	10% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	10% coinsurance	10% coinsurance	Physician certification required. Unlimited visits.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	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)	
For more information on pediatric vision or dental, contact your plan administrator	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**

Blue Cross Blue Shield of Michigan

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

MESSA ABC & ABC Rx

Plan 2 Coins 20%

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/ $7,000 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	20%coinsurance	40% coinsurance	None
	Specialist visit	20%coinsurance	40% 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)	20%coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20%coinsurance	40% coinsurance	May require preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.messa.org	Generic or prescribed over-the-counter drugs	$10 copay/prescription for retail 34-day supply; $20 copay/prescription for retail and mail order 90-day supply	In-Network copay plus an additional 25% of the approved amount	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; $80 copay/prescription for retail and mail order 90-day supply	In-Network copay plus an additional 25% of the approved amount	
	Non-preferred brand-name drugs	$40 copay/prescription for retail 34-day supply; $80 copay/prescription for retail and 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)	20%coinsurance	40% coinsurance	None
	Physician/surgeon fees	20%coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20%coinsurance	20%coinsurance	None
	Emergency medical transportation	20%coinsurance	20%coinsurance	Mileage limits apply
	Urgent care	20%coinsurance	40% 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 have a hospital stay	Facility fee (e.g., hospital room)	20%coinsurance	40% coinsurance	Preauthorization is required
	Physician/surgeon fee	20%coinsurance	40% coinsurance	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	20%coinsurance	40% coinsurance	None
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Notes

The information contained in this summary should in no way be construed as a promise or guarantee of employment or benefits. The company reserves the right to modify, amend, suspend, or terminate any plan at any time for any reason. If there is a conflict between the information in this notice and the actual plan policies, the policies will always govern. Complete details about the benefits can be obtained by reviewing current plan descriptions, contracts, certificates, and policies available from the Employee Services Department.