

MESSA In-Network Plan Comparison - Effective 1/1/2024
Bay City Public Schools - All Employees

	MESSA Choices \$500/\$1,000 0% MESSA Saver Rx	MESSA Choices \$500/\$1,000 10% MESSA Saver Rx	MESSA ABC Plan 1 \$1,600/\$3,200 HSA 0% MESSA ABC Rx	MESSA Balance+ \$1,600/\$3,200 HSA 20% MESSA Balance+ Rx
In-Network Cost Share After Deductible				
Deductible	\$500/\$1,000	\$500/\$1,000	\$1,600/\$3,200	\$1,600/\$3,200
Coinsurance	0%	10%	0%	20%
Teladoc Health virtual 24/7 care for minor illnesses, injuries and mental health copay/coinsurance	\$20	\$20	0%	\$10
Teladoc Health virtual primary care visit copay/coinsurance	\$20	\$20	0%	\$25
Office visit copay/coinsurance	\$20	\$20	0%	\$25
Specialist visit copay/coinsurance	\$20	\$20	0%	\$50
Urgent care copay/coinsurance	\$25	\$25	0%	\$50
Emergency room copay/coinsurance	\$50	\$50	0%	\$200
Total out-of-pocket maximum	\$2,500/\$5,000	\$3,500/\$7,000	\$2,600/\$5,200	\$4,000/\$8,000
Certain Benefit Differences				
Chiropractic manipulations	Up to 38 visits per calendar year, including therapeutic massage; Covered 100% after deductible; \$20 office visit copay may apply	Up to 38 visits per calendar year, including therapeutic massage; Covered 90% after deductible; \$20 office visit copay may apply	Up to 38 visits per calendar year, including therapeutic massage; Covered 100% after deductible	Up to a combined 12 visits per calendar year; \$25 office visit copay applies after deductible
Osteopathic manipulations	Up to 38 visits per calendar year; Covered 100% after deductible; \$20 office visit copay may apply	Up to 38 visits per calendar year; Covered 90% after deductible; \$20 office visit copay may apply	Up to 38 visits per calendar year; Covered 100% after deductible	
Outpatient physical, occupational and speech therapy	Up to a combined 60 visits per calendar year; Covered 100% after deductible	Up to a combined 60 visits per calendar year; Covered 90% after deductible	Up to a combined 60 visits per calendar year; Covered 100% after deductible	Up to a combined 30 visits per calendar year, including therapeutic massage by an approved provider (e.g., chiropractor, MD, DO); Covered 80% after deductible
Bariatric surgery	Covered 100% after deductible	Covered 90% after deductible	Covered 100% after deductible	Not covered
Acupuncture	Covered 100% after deductible	Covered 90% after deductible	Covered 100% after deductible	Not covered
Hearing aids	Covered 100% up to a maximum benefit after deductible	Covered 90% up to a maximum benefit after deductible	Covered 100% up to a maximum benefit after deductible	Not covered

MESSA In-Network Plan Comparison - Effective: 1/1/2024
Bay City Public Schools - Transportation

	MESSA Choices \$500/\$1,000 0% MESSA Saver Rx	MESSA Choices \$500/\$1,000 10% MESSA Saver Rx	MESSA ABC Plan 1 \$1,600/\$3,200 HSA 0% MESSA ABC Rx	MESSA Balance+ \$1,600/\$3,200 HSA 20% MESSA Balance+ Rx
Prescription Drugs	MESSA Saver Rx	MESSA Saver Rx	MESSA ABC Rx (after deductible)	MESSA Balance+ Rx (after deductible)
Up to a 34-day supply				
Generic drugs	\$2 or \$10	\$2 or \$10	Free, \$2 or \$10	Free or \$10
Preferred brand-name drugs	\$20 or \$40	\$20 or \$40	\$20 or \$40	\$40
Nonpreferred brand-name drugs				\$80
Preferred specialty drugs (includes generic specialty and preferred brand specialty)	Specialty drugs included in one of the above pricing categories	Specialty drugs included in one of the above pricing categories	Specialty drugs included in one of the above pricing categories	20% coinsurance (\$0 min - \$150 max)
Nonpreferred specialty drugs				20% coinsurance (\$0 min - \$300 max)
90-day supply				
Generic drugs, Preferred brand-name drugs, Nonpreferred brand-name drugs	2x 1-month supply; Available via retail or mail order	2x 1-month supply; Available via retail or mail order	2x 1-month supply; Available via retail or mail order	3x 1-month supply; Available via retail or mail order
Additional Information				
Free preventive drug lists	Affordable Care Act (ACA) Free Preventive Drug Coverage	Affordable Care Act (ACA) Free Preventive Drug Coverage	Affordable Care Act (ACA) Free Preventive Drug Coverage and the Expanded Free Preventive Drug List; These are FREE before you pay your deductible	Affordable Care Act (ACA) Free Preventive Drug Coverage and the Expanded Free Preventive Drug List; These are FREE before you pay your deductible
Supplemental Plans	Not included	Not included	Not included	Included: MESSA's Accident, Critical Illness and Hospital Indemnity plans

~ Essentials by MESSA Rx and Balance+ Rx plans have several drugs and drug categories that are excluded from coverage, including, but not limited to brand-name drugs that have generic equivalents, erectile dysfunction drugs, brand-name weight loss and prenatal vitamins, and drugs that treat coughs and colds, including most antihistamines.

~ For Saver Rx and ABC Rx, the reduced cost generic drugs at \$2 and brand name drugs at \$20, include medications for asthma, diabetes, coronary artery disease, high blood pressure and high cholesterol.

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

If you have any questions, please contact your MESSA Field Representative, Rahshaan Watson, at 800-292-4910.

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



***Including BCASA, BCESP, Food Service, Food Service Supervisors, Maintenance,
Transportation, Science Technician, MTSS/SSW
Effective January 1, 2024***

INSURANCE OPTIONS	MESSA Choices	MESSA Choices 10%	MESSA ABC Plan 1- HSA		MESSA Balance+		Cash in Lieu
DEDUCTIBLE	\$500/\$1000	\$500/\$1000	\$1600/\$3200	\$1600/\$3200	\$1600/\$3200	\$1600/\$3200	NA
COINSURANCE	0%	10%	0%	0%	20%	20%	NA
Employee ANNUAL COST (12 MO)							
SINGLE	\$1,605.43	\$898.03	\$524.47	\$2,124.47	-\$709.49	\$890.51	\$0.00
2 PERSON	\$4,834.54	\$3,242.98	\$2,402.62	\$5,602.62	-\$373.82	\$2,826.18	\$0.00
FAMILY	\$5,055.09	\$3,074.49	\$2,028.81	\$5,228.81	-\$1,426.47	\$1,773.53	\$0.00
INSURANCE COSTS PER PAY							
	Choices	Choices 10%	ABC Plan 1 - HSA without Contribution	ABC Plan 1 - HSA with Contribution	Balance+ without Contribution	Balance+ with Contribution	Cash in Lieu
Employee AMOUNT PER PAY (26 PAYS*)							
SINGLE	\$61.75	\$34.54	\$20.17	\$81.71	\$0.00	\$34.25	\$0.00
2 PERSON	\$185.94	\$124.73	\$92.41	\$215.49	\$0.00	\$108.70	\$0.00
FAMILY	\$194.43	\$118.25	\$78.03	\$201.11	\$0.00	\$68.21	\$0.00
	Choices	Choices 10%	ABC Plan 1 - HSA without Contribution	ABC Plan 1 - HSA with Contribution	Balance+ without Contribution	Balance+ with Contribution	Cash in Lieu
Employee AMOUNT PER PAY (21 PAYS*)							
SINGLE	\$76.45	\$42.76	\$24.97	\$101.17	\$0.00	\$42.41	\$0.00
2 PERSON	\$230.22	\$154.43	\$114.41	\$266.79	\$0.00	\$134.58	\$0.00
FAMILY	\$240.72	\$146.40	\$96.61	\$248.99	\$0.00	\$84.45	\$0.00
	Choices	Choices 10%	ABC Plan 1 - HSA without Contribution	ABC Plan 1 - HSA with Contribution	Balance+ without Contribution	Balance+ with Contribution	Cash in Lieu
Employee AMOUNT PER PAY (20 PAYS*)							
SINGLE	\$80.27	\$44.90	\$26.22	\$106.22	\$0.00	\$44.53	\$0.00
2 PERSON	\$241.73	\$162.15	\$120.13	\$280.13	\$0.00	\$141.31	\$0.00
FAMILY	\$252.75	\$153.72	\$101.44	\$261.44	\$0.00	\$88.68	\$0.00

*Distribution of pay is dependent on contractual group



***Including BCEA, Central Office, Mechanics, Technology, Early Childhood Facilitators
Effective January 1, 2024***

INSURANCE OPTIONS	MESSA Choices	MESSA Choices 10%	MESSA ABC Plan 1- HSA		MESSA Balance+		Cash in Lieu
DEDUCTIBLE	\$500/\$1000	\$500/\$1000	\$1600/\$3200	\$1600/\$3200	\$1600/\$3200	\$1600/\$3200	N/A
COINSURANCE	0%	10%	0%	0%	20%	20%	N/A
Employee ANNUAL COST (12 MO)							
SINGLE	\$1,534.75	\$832.63	\$462.07	\$2,062.07	-\$762.65	\$837.35	\$0.00
2 PERSON	\$4,675.54	\$3,095.98	\$2,262.10	\$5,462.10	-\$493.34	\$2,706.66	\$0.00
FAMILY	\$4,857.21	\$2,891.61	\$1,853.85	\$5,053.85	-\$1,575.15	\$1,624.85	\$0.00
INSURANCE COSTS PER PAY							
	Choices	Choices 10%	ABC Plan 1 - HSA without Contribution	ABC Plan 1 - HSA with Contribution	Balance+ without Contribution	Balance+ with Contribution	Cash in Lieu
Employee AMOUNT PER PAY (26 PAYS*)							
SINGLE	\$59.03	\$32.02	\$17.77	\$79.31	\$0.00	\$32.21	\$0.00
2 PERSON	\$179.83	\$119.08	\$87.00	\$210.08	\$0.00	\$104.10	\$0.00
FAMILY	\$186.82	\$111.22	\$71.30	\$194.38	\$0.00	\$62.49	\$0.00
	Choices	Choices 10%	ABC Plan 1 - HSA without Contribution	ABC Plan 1 - HSA with Contribution	Balance+ without Contribution	Balance+ with Contribution	Cash in Lieu
Employee AMOUNT PER PAY (21 PAYS*)							
SINGLE	\$73.08	\$39.65	\$22.00	\$98.19	\$0.00	\$39.87	\$0.00
2 PERSON	\$222.64	\$147.43	\$107.72	\$260.10	\$0.00	\$128.89	\$0.00
FAMILY	\$231.30	\$137.70	\$88.28	\$240.66	\$0.00	\$77.37	\$0.00
	Choices	Choices 10%	ABC Plan 1 - HSA without Contribution	ABC Plan 1 - HSA with Contribution	Balance+ without Contribution	Balance+ with Contribution	Cash in Lieu
Employee AMOUNT PER PAY (20 PAYS*)							
SINGLE	\$76.74	\$41.63	\$23.10	\$103.10	\$0.00	\$41.87	\$0.00
2 PERSON	\$233.78	\$154.80	\$113.11	\$273.11	\$0.00	\$135.33	\$0.00
FAMILY	\$242.86	\$144.58	\$92.69	\$252.69	\$0.00	\$81.24	\$0.00

*Distribution of pay is dependent on contractual group

MESSA Dental plan highlights



MESSA

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

Effective Date: 01/01/2024

MESSA Account: Bay City Public Schools

Employee Group: All Employees

Group/Subgroup: PROPOSED

MESSA dental plans are underwritten and administered by Delta Dental of Michigan, a non-profit dental care corporation known for its high quality dental programs. Delta Dental contracts with dentists throughout the U.S. to provide high quality care and 90% of Michigan dentists are in the Delta Dental provider network. MESSA members can easily locate Delta Dental contracting providers by visiting www.messa.org and using the provider directory search provided by Delta Dental.

Plan Features

Diagnostic & Preventive Services 100%	Basic Services 80%	Major Services 80%	Orthodontics 80%
<ul style="list-style-type: none"> • Oral Examination • Prophylaxes • Topical Fluoride* • Brush Biopsy • Emergency Pallative • 2 Cleanings in 12 Months <p>* Fluoride treatments are payable twice in any period of 12 consecutive months for people up to age 19.</p> <p>Rider (If neither box below is checked, you do not have this coverage.)</p> <p><input type="checkbox"/> 3 Cleanings in 12 Months</p> <p><input type="checkbox"/> 4 Cleanings in 12 Months</p>	<ul style="list-style-type: none"> • Radiographs (x-rays)* • Restorative • Crowns** • Oral Surgery • Endodontic Services — treatment for diseased or damaged nerves. • Periodontic Services — treatment for diseases of the gum and teeth-supporting structures. <p>* Bitewing x-rays are payable once in any period of 12 consecutive months. Full mouth panograph is payable once in 5 years.</p> <p>** Payable once in any 5-year period on the same tooth.</p> <p>Rider (If the box below is not checked, you do not have this coverage.)</p> <p><input type="checkbox"/> Sealants: payable on occlusal surface of first permanent molars for patients up to age 9 and for second permanent molars for patients up to age 14 that are free from caries and restorations.</p>	<ul style="list-style-type: none"> • Procedures for the construction of fixed bridgework, enosteal implants, partial and complete dentures. • Payable once in any 5-year period for the same appliances. 	<ul style="list-style-type: none"> • Necessary treatment and procedures required for the correction of abnormal bite. • Orthodontic exam, radiographs and extractions are covered under Diagnostic & Preventive Services and Basic Services. <p>Rider (If the box below is not checked, you do not have this coverage.)</p> <p><input type="checkbox"/> Adult orthodontics: removes the age 19 restriction on Orthodontics coverage.</p>
\$1,500 annual maximum per person Diagnostic & Preventive Services, Basic Services, and Major Services			\$1,500 lifetime maximum per person Orthodontics

For a complete listing of exclusions and limitations that apply to the plan, refer to the Delta Dental of Michigan certificate booklet.

VSP 3 G Benefits



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

Effective Date: 1/1/2024

MESSA Account: Bay City Public Schools

Employee Group: All Employees PROPOSED

In-network providers

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

Out-of-network providers

(Maximum reimbursement to patient)

If you choose to see a doctor who is not in the VSP Signature network, your out-of-pocket costs will likely be higher and you must submit the itemized receipts to VSP for reimbursement. For more information, visit 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	No copayment	\$45
Contact lenses (includes contact lens examination) *		
Elective lenses to improve vision	\$135 allowance	\$115
Medically necessary - to correct <i>keratoconus, irregular astigmatism, irregular corneal curvature or vision to 20/70 in the better eye</i>	MESSA pays 100% of the approved amount	\$200
Eyeglass frames	\$130 allowance	\$55
Eyeglass lenses		
Single vision	MESSA pays 100% of the approved amount	\$38
Bifocal		\$60
Trifocal		\$72
Lenticular		\$108
Eyeglass lens enhancements		
Rose #1 or #2 tint	MESSA pays 100% of the approved amount	Member must pay the difference between the approved amount and the provider charge
Rimless		
Oversize		
Blended		
Photochromic		
Progressive	Not covered	
Tinted		
Single vision	MESSA pays 100% of the approved amount	\$42
Bifocal		\$70
Trifocal		\$84
Lenticular		\$118
Polarized		
Single vision	MESSA pays 100% of the approved amount	\$56
Bifocal		\$90
Trifocal		\$110
Lenticular		\$138

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