

# MESSA In-Network Plan Comparison Exclusively for

APA - UP

Effective: 1/1/2020

All Employees	MESSA Choices \$500/\$1000 0% MESSA Saver Rx	MESSA Choices \$1000/\$2000 0% MESSA Saver Rx	MESSA ABC Plan 1 \$1400/\$2800 HSA 0%MESSA ABC Rx	MESSA ABC Plan 2 \$2000/\$4000 HSA 20% MESSA ABC Rx
<b>In-Network Cost Share After Deductible</b>				
Deductible	\$500/\$1000	\$1000/\$2000	\$1400/\$2800	\$2000/\$4000
Coinsurance	0%	0%	0%	20%
Blue Cross online visit copay/coinsurance	\$20	\$20	0%	20%
Office visit copay/coinsurance	\$20	\$20	0%	20%
Specialist visit copay/coinsurance	\$20	\$20	0%	20%
Urgent care copay/coinsurance	\$25	\$25	0%	20%
Emergency room copay/coinsurance	\$50	\$50	0%	20%
Total out-of-pocket maximum	\$2500/\$5000	\$3000/\$6000	\$2400/\$4800	\$4000/\$6750
<b>Certain Benefit Differences</b>				
Chiropractic manipulations	Up to 38 visits per calendar year, including therapeutic massage. Office visit copay may apply	Up to 38 visits per calendar year, including therapeutic massage. Office visit copay may apply	Up to 38 visits per calendar year, including therapeutic massage.	Up to 38 visits per calendar year, including therapeutic massage. Coinsurance applies
Osteopathic manipulations	Up to 38 visits per calendar year. Office visit copay applies	Up to 38 visits per calendar year. Office visit copay applies	Up to 38 visits per calendar year.	Up to 38 visits per calendar year. Coinsurance applies
Physical, occupational, and speech therapy	Up to a combined 60 visit maximum per calendar year.	Up to a combined 60 visit maximum per calendar year.	Up to a combined 60 visit maximum per calendar year.	Up to a combined 60 visit maximum per calendar year. Coinsurance applies
Bariatric surgery	Covered	Covered	Covered	Covered
Acupuncture	Covered	Covered	Covered	Covered
Hearing aids	Covered up to the maximum benefit, adjusted annually.	Covered up to the maximum benefit, adjusted annually.	Covered up to the maximum benefit, adjusted annually.	Covered up to the maximum benefit, adjusted annually. Coinsurance applies

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<b>Prescription Drugs</b>	<b>MESSA Saver Rx</b>	<b>MESSA Saver Rx</b>	<b>MESSA ABC Rx (after deductible)</b>	<b>MESSA ABC Rx (after deductible)</b>
Retail	34-day supply	34-day supply	34-day supply	34-day supply
Optional mail order 90-day supply	2x copay of 34-day supply	2x copay of 34-day supply	2x copay of 34-day supply	2x copay of 34-day supply
Mandatory mail rider 90-day supply	N/A	N/A	N/A	N/A
Generic drug 34-day supply	\$2 or \$10	\$2 or \$10	Free, \$2 or \$10	Free, \$2 or \$10
Brand drug - preferred 34-day supply	\$20 or \$40	\$20 or \$40	Free, \$20 or \$40	Free, \$20 or \$40
Brand drug - non-preferred 34-day supply				
Rx information	N/A	N/A	An extensive list of FREE preventive drugs. These are FREE before you pay your deductible.	An extensive list of FREE preventive drugs. These are FREE before you pay your deductible.

~ Information on this document is a general overview. Please refer to the plan booklet for more detailed information.

~ 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 deductible is subject to change each Jan. 1 to remain HSA-compatible according to IRS rules governing HSAs.

**If you have any questions, please contact your MESSA Field Representative at 800.292.4910.**

# MESSA Choices Medical plan highlights



**MESSA Account:** APA-UP

**Employee Group:** PAK A

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

## In-network health care benefits for you and your covered dependents

All services must be **medically necessary** and performed by a payable provider.

This is a brief summary of in-network benefits. If you obtain medical services from an out-of-network provider without a referral from an in-network provider, you may have to pay 100 percent of the cost or the applicable out-of-network cost share amounts. For complete coverage details, go to [messa.org](http://messa.org) to log in to your member account or call the MESSA Member Service Center at 800.336.0013 or TTY 888.445.5614.

Plan features	In-network
<p><b>Annual deductible</b> The amount you pay for health care services before your health insurance begins to pay. If one member of the family meets the individual deductible, but the family deductible has not been met, MESSA will pay for covered services for that member only. Covered services for the remaining family members will be paid when the family deductible has been met. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31.</p>	\$500 individual/\$1,000 family
<p><b>Medical copayment</b> A fixed amount you pay for a medical visit.</p>	\$20 Blue Cross online visit, \$20 office visit, \$20 specialist visit, \$25 urgent care, \$50 emergency room
<p><b>Medical coinsurance</b> A fixed percentage you pay for a medical service.</p>	0%
<p><b>Prescription drug coverage</b> Subject to prescription copayments and coinsurance.</p>	Saver Rx
<p><b>Annual out-of-pocket maximums</b> <b>Medical:</b> The most you have to pay for covered services in a calendar year, including deductible, applicable coinsurance and copayments. Charges above approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximums. <b>Prescription:</b> The most you have to pay for prescription copayments and coinsurance in a calendar year.</p>	<p>Medical: \$1,500 individual/\$3,000 family</p> <p>Prescription: \$1,000 individual/\$2,000 family</p>
Covered service	In-network cost share
<p><b>Preventive care</b> Certain services such as annual exams, screenings, childhood and adult immunizations and certain preventive medications.</p>	No cost to you
<p><b>Prenatal and postnatal care</b> Prenatal and postnatal doctor visits.</p>	No cost to you
<p><b>Blue Cross online visit</b></p>	Subject to deductible and Blue Cross online visit copayment
<p><b>Office visit</b> (e.g. primary care physician, obstetrics and gynecology and pediatric visits)</p>	Subject to deductible and office visit copayment
<p><b>Specialist visit</b></p>	Subject to deductible and specialist visit copayment
<p><b>Urgent care</b> Copayment waived if services are required to treat a medical emergency or accidental injury.</p>	Subject to deductible and urgent care copayment
<p><b>Hospital emergency room (ER)</b> Copayment waived if admitted or due to an accidental injury.</p>	Subject to deductible and emergency room copayment If copayment is waived, then coinsurance may apply
<p><b>Allergy testing and therapy</b></p>	Subject to deductible and coinsurance Specialist visit copayment may apply
<p><b>Osteopathic manipulations</b> Performed by an Osteopathic physician. Up to 38 visits per calendar year.</p>	Subject to deductible and office visit copayment
<p><b>Chiropractic services including modalities</b> Up to 38 visits per calendar year.</p>	Subject to deductible and coinsurance Office visit copayment may apply

Covered service	In-network cost share	
<b>Acupuncture</b> Must be performed by an M.D. or D.O.	Subject to deductible and coinsurance Office visit copayment may apply	
<b>Mental health and substance abuse - outpatient care</b>		
<b>Mental health and substance abuse - inpatient care</b>		
<b>Inpatient hospital</b>		
<b>Outpatient physical, occupational and speech therapy</b> Up to a combined benefit maximum of 60 visits per individual per calendar year.		
<b>Diagnostic lab and X-ray</b>		
<b>Radiation and chemotherapy</b>		
<b>Autism - applied behavior analysis (ABA) services</b>		
<b>Hearing care</b> Hearing related services performed by an M.D. or D.O.		
<b>Hearing aids</b> There is a maximum benefit, adjusted annually based on the Consumer Price Index (CPI), for a hearing aid for each ear during a 36-month period.		Subject to deductible and coinsurance
<b>Ambulance</b>		
<b>Bariatric surgery</b>		
<b>Medical supplies</b>		
<b>Durable medical equipment (DME)</b>		
<b>Prosthetics and orthotics</b>		
<b>Home health care</b>		
<b>Skilled nursing facility</b> Up to a maximum of 120 days per calendar year.		
<b>Human organ transplant</b> Must be performed at an approved facility.		
<b>Home delivery of prescription medications</b>		
<p>MESSA members can save time and money by ordering prescription medications through the Express Scripts mail order pharmacy. If your coverage includes a mandatory mail prescription rider, you must obtain most long-term maintenance medications from Express Scripts. For more information, go to <a href="http://messa.org">messa.org</a> to log in to your member account and link to the Express Scripts website. For general questions about your prescription coverage, call MESSA at 800.336.0013 or TTY 888.445.5614. For questions about a prescription order, call Express Scripts at 800.903.8346</p>		
<b>Medical care outside the U.S.</b>		
<p>MESSA members have access to doctors and hospitals with the BCBS Global Core program. You may want to visit the BCBS Global Core program's website (<a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a>) to find in-network providers prior to your departure.</p>		
<b>Covered services and approved amounts</b>		
<p><b>In-network providers</b> bill BCBSM directly. Payments for covered services are based on BCBSM's approved amounts. Your liability is limited to the plan deductible, copayment and coinsurance requirements.</p>		
<p><b>Out-of-network providers</b> may or may not bill BCBSM directly. The member is responsible to the provider for any deductibles, copayments, coinsurance and amounts that are in excess of the approved amount for the services as predetermined by MESSA and BCBSM. These amounts may be substantial.</p>		
<p><i>Medical benefits underwritten by Blue Cross Blue Shield of Michigan (BCBSM) &amp; 4 Ever Life Insurance Company. BCBSM is an independent licensee of the Blue Cross and Blue Shield Association.</i></p>		
<b>Life and accidental death &amp; dismemberment insurance</b>		
<p><b>Life insurance:</b> \$5,000 policy for you.</p>		
<p><b>Accidental death &amp; dismemberment insurance (AD&amp;D):</b> \$5,000 policy or you.</p>		
<p>AD&amp;D terminates at age 65 or when employment ends, whichever comes later.  <i>Life and AD&amp;D insurance underwritten by Life Insurance Company of North America.</i></p>		



# MESSA Choices Medical plan highlights



**MESSA Account:** APA-UP

**Employee Group:** PAK E

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## In-network health care benefits for you and your covered dependents

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This is a brief summary of in-network benefits. If you obtain medical services from an out-of-network provider without a referral from an in-network provider, you may have to pay 100 percent of the cost or the applicable out-of-network cost share amounts. For complete coverage details, go to [messa.org](http://messa.org) to log in to your member account or call the MESSA Member Service Center at 800.336.0013 or TTY 888.445.5614.

Plan features	In-network
<p><b>Annual deductible</b> The amount you pay for health care services before your health insurance begins to pay. If one member of the family meets the individual deductible, but the family deductible has not been met, MESSA will pay for covered services for that member only. Covered services for the remaining family members will be paid when the family deductible has been met. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31.</p>	\$1,000 individual/\$2,000 family
<p><b>Medical copayment</b> A fixed amount you pay for a medical visit.</p>	\$20 Blue Cross online visit, \$20 office visit, \$20 specialist visit, \$25 urgent care, \$50 emergency room
<p><b>Medical coinsurance</b> A fixed percentage you pay for a medical service.</p>	0%
<p><b>Prescription drug coverage</b> Subject to prescription copayments and coinsurance.</p>	Saver Rx
<p><b>Annual out-of-pocket maximums</b> <b>Medical:</b> The most you have to pay for covered services in a calendar year, including deductible, applicable coinsurance and copayments. Charges above approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximums. <b>Prescription:</b> The most you have to pay for prescription copayments and coinsurance in a calendar year.</p>	<p>Medical: \$2,000 individual/\$4,000 family Prescription: \$1,000 individual/\$2,000 family</p>
Covered service	In-network cost share
<p><b>Preventive care</b> Certain services such as annual exams, screenings, childhood and adult immunizations and certain preventive medications.</p>	No cost to you
<p><b>Prenatal and postnatal care</b> Prenatal and postnatal doctor visits.</p>	No cost to you
<p><b>Blue Cross online visit</b></p>	Subject to deductible and Blue Cross online visit copayment
<p><b>Office visit</b> (e.g. primary care physician, obstetrics and gynecology and pediatric visits)</p>	Subject to deductible and office visit copayment
<p><b>Specialist visit</b></p>	Subject to deductible and specialist visit copayment
<p><b>Urgent care</b> Copayment waived if services are required to treat a medical emergency or accidental injury.</p>	Subject to deductible and urgent care copayment
<p><b>Hospital emergency room (ER)</b> Copayment waived if admitted or due to an accidental injury.</p>	Subject to deductible and emergency room copayment If copayment is waived, then coinsurance may apply
<p><b>Allergy testing and therapy</b></p>	Subject to deductible and coinsurance Specialist visit copayment may apply
<p><b>Osteopathic manipulations</b> Performed by an Osteopathic physician. Up to 38 visits per calendar year.</p>	Subject to deductible and office visit copayment
<p><b>Chiropractic services including modalities</b> Up to 38 visits per calendar year.</p>	Subject to deductible and coinsurance Office visit copayment may apply

Covered service	In-network cost share	
<b>Acupuncture</b> Must be performed by an M.D. or D.O.	Subject to deductible and coinsurance Office visit copayment may apply	
<b>Mental health and substance abuse - outpatient care</b>		
<b>Mental health and substance abuse - inpatient care</b>		
<b>Inpatient hospital</b>		
<b>Outpatient physical, occupational and speech therapy</b> Up to a combined benefit maximum of 60 visits per individual per calendar year.		
<b>Diagnostic lab and X-ray</b>		
<b>Radiation and chemotherapy</b>		
<b>Autism - applied behavior analysis (ABA) services</b>		
<b>Hearing care</b> Hearing related services performed by an M.D. or D.O.		
<b>Hearing aids</b> There is a maximum benefit, adjusted annually based on the Consumer Price Index (CPI), for a hearing aid for each ear during a 36-month period.		Subject to deductible and coinsurance
<b>Ambulance</b>		
<b>Bariatric surgery</b>		
<b>Medical supplies</b>		
<b>Durable medical equipment (DME)</b>		
<b>Prosthetics and orthotics</b>		
<b>Home health care</b>		
<b>Skilled nursing facility</b> Up to a maximum of 120 days per calendar year.		
<b>Human organ transplant</b> Must be performed at an approved facility.		

### Home delivery of prescription medications

MESSA members can save time and money by ordering prescription medications through the Express Scripts mail order pharmacy. If your coverage includes a mandatory mail prescription rider, you must obtain most long-term maintenance medications from Express Scripts. For more information, go to [messa.org](http://messa.org) to log in to your member account and link to the Express Scripts website. For general questions about your prescription coverage, call MESSA at 800.336.0013 or TTY 888.445.5614. For questions about a prescription order, call Express Scripts at 800.903.8346

### Medical care outside the U.S.

MESSA members have access to doctors and hospitals with the BCBS Global Core program. You may want to visit the BCBS Global Core program's website ([www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)) to find in-network providers prior to your departure.

### Covered services and approved amounts

**In-network providers** bill BCBSM directly. Payments for covered services are based on BCBSM's approved amounts. Your liability is limited to the plan deductible, copayment and coinsurance requirements.

**Out-of-network providers** may or may not bill BCBSM directly. The member is responsible to the provider for any deductibles, copayments, coinsurance and amounts that are in excess of the approved amount for the services as predetermined by MESSA and BCBSM. These amounts may be substantial.

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

### Life and accidental death & dismemberment insurance

**Life insurance:** \$5,000 policy for you.

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

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

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

# MESSA ABC Plan 1

## Medical plan highlights



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

**MESSA Account:** APA-UP

**Effective Date:** 1/1/2020

**Employee Group:** PAK C

### In-network health care benefits for you and your covered dependents

All services must be medically necessary and performed by a payable provider.

This is a brief summary of in-network benefits. If you obtain medical services from an out-of-network provider without a referral from an in-network provider, you may have to pay 100 percent of the cost or the applicable out-of-network cost share amounts. For complete coverage details, go to [messa.org](http://messa.org) to log in to your member account or call the MESSA Member Service Center at 800.336.0013 or TTY 888.445.5614.

Plan features	In-network
<p><b>Annual deductible</b>                      The amount you pay for health care services and prescription drug purchases before your health insurance begins to pay. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31.</p>	<p>Single coverage: \$1,400                      2-Person &amp; Family coverage: \$2,800</p> <p><i>*Your deductible is subject to change each Jan. 1 according to IRS rules governing HSA-qualified plans.</i></p> <p><i>*When two or more lives are covered under this plan, the entire family deductible must be met before claims are paid for any individual.</i></p>
<p><b>Medical coinsurance</b>                      A fixed percentage you pay for a medical service.</p>	<p>0%</p>
<p><b>Prescription drug coverage</b>                      Under federal law governing HSA-qualified plans, prescription drugs are subject to the deductible (other than MESSA's free preventive prescriptions). After deductible is met, applicable prescription copayments and/or coinsurance apply.  <i>See Free preventive prescriptions below.</i></p>	<p>ABC Rx</p>
<p><b>Annual out-of-pocket maximums</b>                      The most you have to pay for covered medical services and prescriptions in a calendar year, including deductible, copayments and coinsurance. Charges above approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximum.</p>	<p>Single coverage: \$2,400                      2-Person &amp; Family coverage: \$4,800</p>
<p><b>In-network services covered at no cost to you</b></p>	
<p><b>Free preventive prescriptions</b>                      MESSA ABC covers an extensive list of FREE preventive prescriptions that have no deductible, copayment or coinsurance, including cholesterol and blood pressure medications, weight loss medications, prenatal vitamins, contraceptives and many more.</p>	
<p><b>Preventive care and prenatal care</b>                      Certain services such as annual exams, screenings, childhood and adult immunizations, certain preventive medications and prenatal doctor visits.</p>	

### In-network services subject to deductible and applicable coinsurance

<b>Blue Cross online visit</b>	<b>Urgent care</b>
<b>Office visit</b>	<b>Hospital emergency room (ER)</b>
<b>Chiropractic services including modalities</b> Up to 38 visits per calendar year.	<b>Osteopathic manipulations</b> Performed by an Osteopathic physician. Up to 38 visits per calendar year.
<b>Inpatient hospital</b>	<b>Autism - applied behavior analysis (ABA) services</b>
<b>Outpatient physical, occupational and speech therapy</b> Up to a combined benefit maximum of 60 visits per individual per calendar year.	<b>Hearing aids</b> There is a maximum benefit, adjusted annually based on the Consumer Price Index (CPI), for a hearing aid for each ear during a 36-month period.
<b>Hearing care</b> Hearing related services performed by an M.D. or D.O.	<b>Acupuncture</b> Must be performed by an M.D. or D.O.
<b>Diagnostic lab and X-ray</b>	<b>Radiation and chemotherapy</b>
<b>Allergy testing and therapy</b>	<b>Bariatric surgery</b>
<b>Mental health and substance abuse - inpatient and outpatient care</b>	<b>Ambulance</b>
<b>Medical supplies</b>	<b>Durable medical equipment (DME)</b>
<b>Prosthetics and orthotics</b>	<b>Home health care</b>
<b>Skilled nursing facility</b> Up to a maximum of 120 days per calendar year.	<b>Human organ transplant</b> Must be performed at an approved facility.

### Home delivery of prescription medications

MESSA members can save time and money by ordering prescription medications through the Express Scripts mail order pharmacy. If your coverage includes a mandatory mail prescription rider, you must obtain most long-term maintenance medications from Express Scripts. For more information, go to [messa.org](http://messa.org) to log in to your member account and link to the Express Scripts website. For general questions about your prescription coverage, call MESSA at 800.336.0013 or TTY 888.445.5614. For questions about a prescription order, call Express Scripts at 800.903.8346

### Medical care outside the U.S.

MESSA members have access to doctors and hospitals with the BCBS Global Core program. You may want to visit the BCBS Global Core program's website ([www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)) to find in-network providers prior to your departure.

### Covered services and approved amounts

**In-network providers** bill BCBSM directly. Payments for covered services are based on BCBSM's approved amounts. Your liability is limited to the plan deductible, copayment and coinsurance requirements.

**Out-of-network providers** may or may not bill BCBSM directly. The member is responsible to the provider for any deductibles, copayments, coinsurance and amounts that are in excess of the approved amount for the services as predetermined by MESSA and BCBSM. These amounts may be substantial.

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

### Life and accidental death & dismemberment insurance

Life insurance: \$5,000 policy for you.

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

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

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



# MESSA ABC Plan 2

## Medical plan highlights



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

**MESSA Account:** APA-UP

**Effective Date:** 1/1/2020

**Employee Group:** PAK D

### In-network health care benefits for you and your covered dependents

All services must be medically necessary and performed by a payable provider.

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Plan features	In-network
<p><b>Annual deductible</b>                      The amount you pay for health care services and prescription drug purchases before your health insurance begins to pay. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31.</p>	<p>Single coverage: \$2,000                      2-Person &amp; Family coverage: \$4,000  <i>*When two or more lives are covered under this plan, the entire family deductible must be met before claims are paid for any individual.</i></p>
<p><b>Medical coinsurance</b>                      A fixed percentage you pay for a medical service.</p>	<p>20%</p>
<p><b>Prescription drug coverage</b>                      Under federal law governing HSA-qualified plans, prescription drugs are subject to the deductible (other than MESSA's free preventive prescriptions). After deductible is met, applicable prescription copayments and/or coinsurance apply.  <i>See Free preventive prescriptions below.</i></p>	<p>ABC Rx</p>
<p><b>Annual out-of-pocket maximums</b>                      The most you have to pay for covered medical services and prescriptions in a calendar year, including deductible, copayments and coinsurance. Charges above approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximum.</p>	<p>Single coverage: \$4,000                      2-Person &amp; Family coverage: \$6,900</p>
<p style="text-align: center;"><b>In-network services covered at no cost to you</b></p>	
<p><b>Free preventive prescriptions</b>                      MESSA ABC covers an extensive list of FREE preventive prescriptions that have no deductible, copayment or coinsurance, including cholesterol and blood pressure medications, weight loss medications, prenatal vitamins, contraceptives and many more.</p>	
<p><b>Preventive care and prenatal care</b>                      Certain services such as annual exams, screenings, childhood and adult immunizations, certain preventive medications and prenatal doctor visits.</p>	

### In-network services subject to deductible and applicable coinsurance

<b>Blue Cross online visit</b>	<b>Urgent care</b>
<b>Office visit</b>	<b>Hospital emergency room (ER)</b>
<b>Chiropractic services including modalities</b> Up to 38 visits per calendar year.	<b>Osteopathic manipulations</b> Performed by an Osteopathic physician. Up to 38 visits per calendar year.
<b>Inpatient hospital</b>	<b>Autism - applied behavior analysis (ABA) services</b>
<b>Outpatient physical, occupational and speech therapy</b> Up to a combined benefit maximum of 60 visits per individual per calendar year.	<b>Hearing aids</b> There is a maximum benefit, adjusted annually based on the Consumer Price Index (CPI), for a hearing aid for each ear during a 36-month period.
<b>Hearing care</b> Hearing related services performed by an M.D. or D.O.	<b>Acupuncture</b> Must be performed by an M.D. or D.O.
<b>Diagnostic lab and X-ray</b>	<b>Radiation and chemotherapy</b>
<b>Allergy testing and therapy</b>	<b>Bariatric surgery</b>
<b>Mental health and substance abuse - inpatient and outpatient care</b>	<b>Ambulance</b>
<b>Medical supplies</b>	<b>Durable medical equipment (DME)</b>
<b>Prosthetics and orthotics</b>	<b>Home health care</b>
<b>Skilled nursing facility</b> Up to a maximum of 120 days per calendar year.	<b>Human organ transplant</b> Must be performed at an approved facility.

### Home delivery of prescription medications

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### Medical care outside the U.S.

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### Covered services and approved amounts

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### Life and accidental death & dismemberment insurance

Life insurance: \$5,000 policy for you.

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

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

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