# MESSA Choices
# Medical plan highlights

MESSA
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East Lansing, Michigan 48826-2560
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**Effective Date: 1/1/2027**

**MESSA Account: Wayne Westland Comm Schools**

**Employee Group: All Eligible Employees**

**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% of the cost or the applicable out-of-network cost share amounts. For coverage details, go to messa.org to log in to your MyMESSA account or call the MESSA Member Service Center at 800-336-0013 or TTY 888-445-5614.

| Plan features | In-network |
|---|---|
| **Annual deductible**<br>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. | $1,000 individual/$2,000 family |
| **Medical copayment**<br>A fixed amount you pay for a medical visit. | $20 Teladoc Health 24/7 care for minor illnesses, injuries and mental health, $20 Teladoc virtual primary care visit, $20 office visit for medical, mental health and/or substance use disorder treatment, $20 specialist visit, $25 urgent care, $50 emergency room, if not admitted |
| **Medical coinsurance**<br>A fixed percentage you pay for a medical service. | 0% |
| **Prescription drug coverage**<br>Subject to prescription copayments and coinsurance. | 3-Tier Rx |
| **Annual out-of-pocket maximums**<br>The most you have to pay for covered medical 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.<br>**Prescription:** The most you have to pay for prescription copayments and coinsurance in a calendar year. | Medical: $2,000 individual/$4,000 family<br><br>Prescription: $2,000 individual/$4,000 family |
| **In-network preventive care – no cost to you** | |
| **Preventive care**<br>Certain services such as annual exams, screenings, childhood and adult immunizations, and certain preventive medications. | **Prenatal and postnatal care**<br>Prenatal and postnatal doctor visits. |
| **In-network services subject to deductible and applicable copayment** | |
| **Emergency room (ER)**<br>Copayment waived if admitted or due to an accidental injury. | **Mental health and substance use disorder - outpatient care** |
| **Office visit**<br>e.g. primary care physican, obstetrics and gynecology and pediatric visits. | **Specialist visit** |

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| **Teladoc Health visits**<br>24/7 care for minor illnesses, injuries and mental health; virtual primary care visits. | **Urgent care**<br>Copayment waived if services are required to treat a medical emergency or accidental injury. |
| **In-network services subject to deductible and applicable coinsurance** | |
| **Acupuncture**<br>Must be performed by an M.D. or D.O or a registered acupuncturist. | **Allergy testing and therapy**<br>Subject to deductible and coinsurance. Office visit copayment may apply |
| **Ambulance** | **Autism - applied behavior analysis (ABA) services** |
| **Bariatric surgery** | **Chiropractic services including modalities**<br>Up to 38 visits per calendar year. |
| **Diagnostic lab and X-ray** | **Durable medical equipment (DME)** |
| **Hearing aids**<br>There is a maximum benefit for a hearing aid for each ear during a 36-month period. | **Hearing care**<br>Hearing related services performed by an M.D. or D.O. |
| **Home health care** | **Human organ transplant**<br>Must be performed at an approved facility. |
| **Inpatient hospital** | **Medical supplies** |
| **Mental health and substance use disorder - inpatient care** | **Osteopathic manipulations**<br>Performed by an Osteopathic physician. Up to 38 visits per |
| **Outpatient physical, occupational and speech therapy**<br>Up to a combined benefit max of 60 visits per individual per calendar year. | **Prosthetics and orthotics** |
| **Radiation and chemotherapy** | **Skilled nursing facility**<br>Up to a max of 120 days per calendar year. |
| **Home delivery of prescription medications** | |
| MESSA members can save time and money by ordering prescription medications through the Optum Rx mail order pharmacy. If your coverage includes a mandatory mail prescription rider, you must obtain most long-term maintenance medications from Optum Rx. For more information, go to messa.org to log in to your MyMESSA account and link to the Optum Rx 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 Optum Rx at 800-903-8346. | |
| **Medical care outside the U.S.** | |
| MESSA members have access to doctors and hospitals with the BCBS Global Core program. You may want to visit the BCBS Global Core program's website (www.bcbsglobalcore.com) to find in-network providers prior to your departure. | |
| **Covered services and approved amounts** | |
| **In-network providers** bill BCBSM directly. Payments for covered services are based on BCBSM's approved amounts. Your liability is limited to the plan deductible, copayment and coinsurance requirements. | |
| **Out-of-network providers** may or may not bill BCBSM directly. The member is responsible to the provider for any deductibles, copayments, coinsurance and amounts that are in excess of the approved amount for the services as predetermined by MESSA and BCBSM. These amounts may be substantial. | |
| *Medical benefits underwritten by Blue Cross Blue Shield of Michigan (BCBSM) & 4 Ever Life Insurance Company. BCBSM is an independent licensee of the Blue Cross and Blue Shield Association.* | |
| **Life and accidental death & dismemberment insurance** | |
| **Life insurance:** $5,000 policy for you. | |
| **Accidental death & dismemberment insurance (AD&D):** $5,000 policy for you. | |
| *Life and AD&D insurance underwritten by Life Insurance Company of North America.* | |