

MESSA In-Network Plan Comparison - Effective 1/1/2023
Lake Shore Public Schools - All Employees

	MESSA Choices \$1,000/\$2,000 20% 3-Tier Rx with Mandatory Mail	MESSA ABC Plan 1 \$1,500/\$3,000 0% 3-Tier Rx with Mandatory Mail	MESSA ABC Plan 1 \$1,500/\$3,000 20% 3-Tier Rx with Mandatory Mail	MESSA ABC Plan 2 \$2,000/\$4,000 20% 3-Tier Rx	Essentials by MESSA \$375/\$750 20% Essentials by MESSA
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Employee Monthly Premium Share - 2023 Hard Cap and 1.25% Medical Discount

Single	\$92.92	\$127.44	\$57.81	\$27.44	\$0.00
2person	\$305.06	\$382.73	\$226.08	\$157.73	\$54.62
Family	\$302.32	\$398.97	\$204.03	\$118.97	\$0.00

In-Network Cost Share After Deductible

Deductible	\$1,000/\$2,000	\$1,500/\$3,000	\$1,500/\$3,000	\$2,000/\$4,000	\$375/\$750
Coinsurance	20%	0%	20%	20%	20%
Blue Cross online visit copay/coinsurance	\$20	0%	20%	20%	\$10
Office visit copay/coinsurance	\$20	0%	20%	20%	\$25
Specialist visit copay/coinsurance	\$20	0%	20%	20%	\$50
Urgent care copay/coinsurance	\$25	0%	20%	20%	\$50
Emergency room copay/coinsurance	\$50	0%	20%	20%	\$200
Total out-of-pocket maximum	\$5,000/\$10,000	\$3,500/\$7,000	\$4,500/\$7,500	\$5,000/\$7,500	\$9,100/\$18,200

Certain Benefit Differences

Chiropractic manipulations	Up to 38 visits per calendar year, including therapeutic massage; Covered 80% after deductible; \$20 office visit copay may apply	Up to 38 visits per calendar year, including therapeutic massage; Covered 100% after deductible	Up to 38 visits per calendar year, including therapeutic massage; Covered 80% after deductible	Up to 38 visits per calendar year, including therapeutic massage; Covered 80% 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 80% after deductible; \$20 office visit copay may apply	Up to 38 visits per calendar year; Covered 100% after deductible	Up to 38 visits per calendar year; Covered 80% after deductible	Up to 38 visits per calendar year; Covered 80% after deductible	
Outpatient physical, occupational and speech therapy	Up to a combined 60 visits per calendar year; Covered 80% after deductible	Up to a combined 60 visits per calendar year; Covered 100% after deductible	Up to a combined 60 visits per calendar year; Covered 80% after deductible	Up to a combined 60 visits per calendar year; Covered 80% after deductible	Up to a combined 30 visits per calendar year, including therapeutic massage by a chiropractor; Covered 80% after deductible
Bariatric surgery	Covered 80% after deductible	Covered 100% after deductible	Covered 80% after deductible	Covered 80% after deductible	Not covered
Acupuncture	Covered 80% after deductible	Covered 100% after deductible	Covered 80% after deductible	Covered 80% after deductible	Not covered
Hearing aids	Covered 80% up to a maximum benefit after deductible	Covered 100% up to a maximum benefit after deductible	Covered 80% up to a maximum benefit after deductible	Covered 80% up to a maximum benefit after deductible	Not covered

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Prescription Drugs	3-Tier Rx with Mandatory Mail	3-Tier Rx with Mandatory Mail (after deductible)	3-Tier Rx with Mandatory Mail (after deductible)	3-Tier Rx (after deductible)	Essentials by MESSA
34-day supply					
Generic drug	\$10	Free or \$10	Free or \$10	Free or \$10	\$10
Preferred brand drug	20% coinsurance (\$40 min - \$80 max)	Free or 20% coinsurance (\$40 min - \$80 max)	Free or 20% coinsurance (\$40 min - \$80 max)	Free or 20% coinsurance (\$40 min - \$80 max)	20% coinsurance (\$40 min - \$80 max)
Non-preferred brand drug	20% coinsurance (\$60 min - \$100 max)	20% coinsurance (\$60 min - \$100 max)	20% coinsurance (\$60 min - \$100 max)	20% coinsurance (\$60 min - \$100 max)	20% coinsurance (\$60 min - \$100 max)
90-day supply					
Generic drug, Preferred brand drug, Non-preferred brand drug	2.5x copay of applicable 34-day supply; Only available via mail order	2.5x copay of applicable 34-day supply; Only available via mail order	2.5x copay of applicable 34-day supply; Only available via mail order	2.5x copay of applicable 34-day supply; Available via retail or mail order	3x copay of applicable 34-day supply; Available via retail or mail order
Additional Rx Information					
Free preventive drug lists	Affordable Care Act (ACA) Free Preventive Drug Coverage	Affordable Care Act (ACA) Free Preventive Drug Coverage and the extended list of ABC Free Preventive Prescriptions; These are FREE before you pay your deductible	Affordable Care Act (ACA) Free Preventive Drug Coverage and the extended list of ABC Free Preventive Prescriptions; These are FREE before you pay your deductible	Affordable Care Act (ACA) Free Preventive Drug Coverage and the extended list of ABC Free Preventive Prescriptions; These are FREE before you pay your deductible	Affordable Care Act (ACA) Free Preventive Drug Coverage

~ The MESSA rate includes the \$1.50 PMPM cost for Basic Term Life. It does not include the EA1 Rider which has an additional monthly cost of \$0.10 for single coverage, \$0.24 for 2person, and \$0.28 for family coverage.

~ The Essentials by MESSA Rx plan has several drugs and drug categories that are excluded from coverage, including, but not limited to brand-name drugs that have generic equivalents, lifestyle drugs (drugs for erectile dysfunction or weight loss), drugs used to treat heartburn and acid reflux (except select generic versions), drugs that treat coughs and colds, including most antihistamines and prenatal vitamins.

~ The out-of-pocket maximum (OOPM) for Essentials by MESSA, is subject to change each Jan. 1 according to the maximum limit allowed by the Affordable Care Act.

~ 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, Heather Scott, at 800.292.4910.

Information on this document is a general overview. Refer to MESSA.org and the plan booklets for additional information.

MESSA Choices

Medical plan highlights

**Plan highlighted in
Orange on the Plan
Comparison and the
Cost Share Sheet**



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East Lansing, Michigan 48826-2560
517.332.2581 • 800.292.4910

Effective Date: 1/1/2023

MESSA Account: Lake Shore Public Schools

Employee Group: 566ABDH AdminTeachSupportPTTeach; 566C Adult Ed Emp Hird Aft 2015; 556G Adult Ed Emp Hrd Before 2015

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 coverage details, go to messa.org to log in to your member account or call the MESSA Member Service Center at 800.336.0013 or TTY 888.445.5614.

Plan features	In-network
Annual deductible - 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.	\$1000 individual/\$2000 family
Medical copayment - A fixed amount you pay for a medical visit.	\$20 Blue Cross online visit, \$20 office visit, \$20 specialist visit, \$25 urgent care, \$50 emergency room
Medical coinsurance - A fixed percentage you pay for a medical service.	20%
Prescription drug coverage - Subject to prescription copayments and coinsurance.	3-Tier Rx with mandatory mail
Annual out-of-pocket maximums Medical: 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. Prescription: The most you have to pay for prescription copayments and coinsurance in a calendar year.	Medical: \$3000 individual/\$6000 family Prescription: \$2000 individual/\$4000 family
Covered service	In-network cost share
Preventive care - Certain services such as annual exams, screenings, childhood and adult immunizations and certain preventive medications.	No cost to you
Prenatal and postnatal care - Prenatal and postnatal doctor visits.	
Blue Cross online visit	Subject to deductible and Blue Cross online visit copayment
Office visit - e.g. primary care physician, obstetrics and gynecology and pediatric visits	Subject to deductible and office visit copayment
Specialist visit	Subject to deductible and specialist visit copayment
Urgent care - Copayment waived if services are required to treat a medical emergency or accidental injury.	Subject to deductible and urgent care copayment
Hospital emergency room (ER) - Copayment waived if admitted or due to an accidental injury.	Subject to deductible and emergency room copayment If copayment is waived, then coinsurance may apply
Allergy testing and therapy	Subject to deductible and coinsurance Specialist visit copayment may apply
Osteopathic manipulations - Performed by an Osteopathic physician. Up to 38 visits per calendar year.	Subject to deductible and office visit copayment

Covered service	In-network cost share
Chiropractic services including modalities - Up to 38 visits per calendar year.	Subject to deductible and coinsurance Office visit copayment may apply
Acupuncture - Must be performed by an M.D. or D.O.	Subject to deductible and coinsurance
Mental health and substance abuse - outpatient care	Office visit copayment may apply
Mental health and substance abuse - inpatient care	Subject to deductible and coinsurance
Inpatient hospital	
Outpatient physical, occupational and speech therapy - Up to a combined benefit max of 60 visits per individual per calendar year.	
Diagnostic lab and X-ray	
Radiation and chemotherapy	
Autism - applied behavior analysis (ABA) services	
Hearing care - Hearing related services performed by an M.D. or D.O.	
Hearing aids - There is a maximum benefit for a hearing aid for each ear during a 36-month period.	
Ambulance	
Bariatric surgery	
Medical supplies	
Durable medical equipment (DME)	
Prosthetics and orthotics	
Home health care	
Skilled nursing facility - Up to a max of 120 days per calendar year.	
Human organ transplant - Must be performed at an approved facility.	
Home delivery of prescription medications	
MESSA members can save time and money by ordering prescription medications through the OptumRx mail order pharmacy. If your coverage includes a mandatory mail prescription rider, you must obtain most long-term maintenance medications from OptumRx. For more information, go to messa.org to log in to your member account and link to the OptumRx 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 OptumRx 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.	
<i>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.</i>	
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. <i>Life and AD&D insurance underwritten by Life Insurance Company of North America.</i>	

MESSA ABC Plan 1

Medical plan highlights

Plan highlighted in Violet on the Plan Comparison and the Cost Share Sheet



MESSA.

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Plan features	In-network
<p>Annual deductible The amount you pay for health care services and prescription drug purchases before your health insurance begins to pay. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31.</p>	<p>Single coverage: \$1500</p> <p>2-Person & Family coverage: \$3000</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>Medical coinsurance A fixed percentage you pay for a medical service.</p>	<p>0%</p>
<p>Prescription drug coverage Under federal law governing HSA-qualified plans, prescription drugs are subject to the deductible (other than MESSA's free preventive prescriptions). After deductible is met, applicable prescription copayments and/or coinsurance apply. See <i>Free preventive prescriptions below</i>.</p>	<p>3-Tier Rx with Mandatory Mail</p>
<p>Annual out-of-pocket maximums The most you have to pay for covered medical services and prescriptions in a calendar year, including deductible, copayments and coinsurance. Charges above approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximum.</p>	<p>Single coverage: \$3500</p> <p>2-Person & Family coverage: \$7000</p>
In-network services covered at no cost to you	
<p>Free preventive prescriptions MESSA ABC covers an extensive list of FREE preventive prescriptions that have no deductible, copayment or coinsurance, including cholesterol and blood pressure medications, weight loss medications, prenatal vitamins, contraceptives and many more.</p>	
<p>Preventive care and prenatal care Certain services such as annual exams, screenings, childhood and adult immunizations, certain preventive medications and prenatal doctor visits.</p>	

In-network services subject to deductible and applicable coinsurance	
Blue Cross online visit	Urgent care
Office visit	Hospital emergency room (ER)
Chiropractic services including modalities Up to 38 visits per calendar year.	Osteopathic manipulations Performed by an Osteopathic physician. Up to 38 visits per calendar year.
Inpatient hospital	Autism - applied behavior analysis (ABA) services
Outpatient physical, occupational and speech therapy Up to a combined benefit maximum of 60 visits per individual per calendar year.	Hearing aids There is a maximum benefit for a hearing aid for each ear during a 36-month period.
Hearing care Hearing related services performed by an M.D. or D.O.	Acupuncture Must be performed by an M.D. or D.O.
Diagnostic lab and X-ray	Radiation and chemotherapy
Allergy testing and therapy	Bariatric surgery
Mental health and substance abuse - inpatient and outpatient care	Ambulance
Medical supplies	Durable medical equipment (DME)
Prosthetics and orthotics	Home health care
Skilled nursing facility Up to a maximum of 120 days per calendar year.	Human organ transplant Must be performed at an approved facility.
Home delivery of prescription medications	
<p>MESSA members can save time and money by ordering prescription medications through the OptumRx mail order pharmacy. If your coverage includes a mandatory mail prescription rider, you must obtain most long-term maintenance medications from OptumRx. For more information, go to messa.org to log in to your member account and link to the OptumRx 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 OptumRx at 800.903.8346</p>	
Medical care outside the U.S.	
<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 (www.bcbsglobalcore.com) to find in-network providers prior to your departure.</p>	
Covered services and approved amounts	
<p>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.</p>	
<p>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.</p>	
<p><i>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.</i></p>	
Life and accidental death & dismemberment insurance	
<p>Life insurance: \$5,000 policy for you.</p>	
<p>Accidental death & dismemberment insurance (AD&D): \$5,000 policy for you.</p>	
<p>AD&D terminates at age 65 or when employment ends, whichever comes later. <i>Life and AD&D insurance underwritten by Life Insurance Company of North America.</i></p>	

MESSA ABC Plan 1

Medical plan highlights

Plan highlighted in
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Comparison and the
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MESSA.

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Plan features	In-network
<p>Annual deductible The amount you pay for health care services and prescription drug purchases before your health insurance begins to pay. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31.</p>	<p>Single coverage: \$1500</p> <p>2-Person & Family coverage: \$3000</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>Medical coinsurance A fixed percentage you pay for a medical service.</p>	<p>20%</p>
<p>Prescription drug coverage Under federal law governing HSA-qualified plans, prescription drugs are subject to the deductible (other than MESSA's free preventive prescriptions). After deductible is met, applicable prescription copayments and/or coinsurance apply. <i>See Free preventive prescriptions below.</i></p>	<p>3-Tier Rx with Mandatory Mail</p>
<p>Annual out-of-pocket maximums The most you have to pay for covered medical services and prescriptions in a calendar year, including deductible, copayments and coinsurance. Charges above approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximum.</p>	<p>Single coverage: \$4500</p> <p>2-Person & Family coverage: \$7500</p>
<p>In-network services covered at no cost to you</p>	
<p>Free preventive prescriptions MESSA ABC covers an extensive list of FREE preventive prescriptions that have no deductible, copayment or coinsurance, including cholesterol and blood pressure medications, weight loss medications, prenatal vitamins, contraceptives and many more.</p>	
<p>Preventive care and prenatal care Certain services such as annual exams, screenings, childhood and adult immunizations, certain preventive medications and prenatal doctor visits.</p>	

In-network services subject to deductible and applicable coinsurance

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

Home delivery of prescription medications

MESSA members can save time and money by ordering prescription medications through the OptumRx mail order pharmacy. If your coverage includes a mandatory mail prescription rider, you must obtain most long-term maintenance medications from OptumRx. For more information, go to messa.org to log in to your member account and link to the OptumRx 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 OptumRx at 800.903.8346

Medical care outside the U.S.

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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

Plan highlighted in
Green on the Plan
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Plan features	In-network
<p>Annual deductible The amount you pay for health care services and prescription drug purchases before your health insurance begins to pay. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31.</p>	<p>Single coverage: \$2000 2-Person & Family coverage: \$4000 <i>*When two or more lives are covered under this plan, the entire family deductible must be met before claims are paid for any individual.</i></p>
<p>Medical coinsurance A fixed percentage you pay for a medical service.</p>	<p>20%</p>
<p>Prescription drug coverage Under federal law governing HSA-qualified plans, prescription drugs are subject to the deductible (other than MESSA's free preventive prescriptions). After deductible is met, applicable prescription copayments and/or coinsurance apply. See <i>Free preventive prescriptions below</i>.</p>	<p>3-Tier Rx</p>
<p>Annual out-of-pocket maximums The most you have to pay for covered medical services and prescriptions in a calendar year, including deductible, copayments and coinsurance. Charges above approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximum.</p>	<p>Single coverage: \$5000 2-Person & Family coverage: \$7500</p>
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Allergy testing and therapy	Bariatric surgery
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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 coverage details, go to messa.org to log in to your member account or call the MESSA Member Service Center at 800.336.0013 or TTY 888.445.5614.

Plan features	In-network
Annual deductible 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.	\$375 individual/\$750 family
Medical copayment A fixed amount you pay for a medical visit.	\$10 Blue Cross online visit, \$25 office visit, \$50 specialist visit, \$50 urgent care, \$200 emergency room
Medical coinsurance A fixed percentage you pay for a medical service.	20%
Prescription drug coverage Subject to prescription copayments and coinsurance.	Essentials by MESSA
Annual out-of-pocket maximums The most you have to pay for covered medical services and prescriptions in a calendar year, including deductible, copayments and coinsurance. Charges above approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximum.	\$9100 individual/\$18200 family
Covered service	In-network cost share
Preventive care Certain services such as annual exams, screenings, childhood and adult immunizations and certain preventive medications.	No cost to you
Prenatal and postnatal care Prenatal and postnatal doctor visits.	
Blue Cross online visit	Subject to deductible and Blue Cross online visit copayment
Office visit e.g. primary care physician, obstetrics and gynecology and pediatric visits	Subject to deductible and office visit copayment
Specialist visit	Subject to deductible and specialist visit copayment
Urgent care	Subject to deductible and urgent care copayment
Hospital emergency room (ER) Copayment waived if admitted or due to an accidental injury.	Subject to deductible and emergency room copayment
Chiropractic and Osteopathic manipulations Up to a combined 12 visits per calendar year.	Subject to deductible and office visit copayment
Allergy testing and therapy	Subject to deductible and coinsurance Specialist visit copayment may apply

Covered service	In-network cost share
Mental health and substance abuse - outpatient care	Subject to deductible and coinsurance Office visit copayment may apply
Mental health and substance abuse - inpatient care	Subject to deductible and coinsurance
Inpatient hospital	
Outpatient physical, occupational and speech therapy Up to a combined benefit maximum of 30 visits per individual per calendar year, including massage therapy performed by a chiropractor.	
Diagnostic lab and X-ray	
Radiation and chemotherapy	
Autism - applied behavior analysis (ABA) services	
Hearing care Hearing related services performed by an M.D., D.O. or an audiologist (AUD) performing for the audiogram hearing evaluation and testing.	
Ambulance	
Medical supplies	
Durable medical equipment (DME) Must be obtained from a payable DME provider.	
Prosthetics and orthotics	
Home health care	
Skilled nursing facility Up to a maximum of 120 days per calendar year.	
Human organ transplant Must be performed at an approved facility.	
Home delivery of prescription medications	
MESSA members can save time and money by ordering prescription medications through the OptumRx mail order pharmacy. For more information, go to messa.org to log in to your member account and link to the OptumRx 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 OptumRx 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.	
<i>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.</i>	
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. <i>Life and AD&D insurance underwritten by Life Insurance Company of North America.</i>	

Premium Cost Sharing Amounts

2023

NU, LFT, LFES, AFSCME, ADULT ED			MESSA Monthly Premium	Monthly Hard Cap paid by district	Emp Share Per month	Emp Share 26 Pays	Emp Share 21 pays	Emp Share 20 Pays	Emp Share 23 Pays	ANNUAL DISTRICT COST	ANNUAL EMPLOYEE COST
	ESSENTIALS BY MESSA	S	\$ 598.24	\$ 616.62	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 7,399.44	\$ -
	ESSENTIALS BY MESSA	2P	\$ 1,344.17	\$ 1,289.55	\$ 54.62	\$ 25.21	\$ 31.21	\$ 32.77	\$ 28.50	\$ 15,474.60	\$ 655.44
	ESSENTIALS BY MESSA	F	\$ 1,672.37	\$ 1,681.70	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 20,180.40	\$ -
	CHOICES \$1000/\$2000 W/20% 3-TIER RX MM	S	\$ 709.54	\$ 616.62	\$ 92.92	\$ 42.89	\$ 53.10	\$ 55.75	\$ 48.48	\$ 7,399.44	\$ 1,115.04
	CHOICES \$1000/\$2000 W/20% 3-TIER RX MM	2P	\$ 1,594.61	\$ 1,289.55	\$ 305.06	\$ 140.80	\$ 174.32	\$ 183.04	\$ 159.16	\$ 15,474.60	\$ 3,660.72
	CHOICES \$1000/\$2000 W/20% 3-TIER RX MM	F	\$ 1,984.02	\$ 1,681.70	\$ 302.32	\$ 139.53	\$ 172.75	\$ 181.39	\$ 157.73	\$ 20,180.40	\$ 3,627.84
	ABC 1 W/0% 3-TIER RX MM	S	\$ 744.06	\$ 616.62	\$ 127.44	\$ 58.82	\$ 72.82	\$ 76.46	\$ 66.49	\$ 7,399.44	\$ 1,529.28
	ABC 1 W/0% 3-TIER RX MM	2P	\$ 1,672.28	\$ 1,289.55	\$ 382.73	\$ 176.64	\$ 218.70	\$ 229.64	\$ 199.69	\$ 15,474.60	\$ 4,592.76
	ABC 1 W/0% 3-TIER RX MM	F	\$ 2,080.67	\$ 1,681.70	\$ 398.97	\$ 184.14	\$ 227.98	\$ 239.38	\$ 208.16	\$ 20,180.40	\$ 4,787.64
	ABC 1 W/20% 3-TIER RX MM \$1500/\$3000	S	\$ 674.43	\$ 616.62	\$ 57.81	\$ 26.68	\$ 33.03	\$ 34.69	\$ 30.16	\$ 7,399.44	\$ 693.72
	ABC 1 W/20% 3-TIER RX MM \$1500/\$3000	2P	\$ 1,515.63	\$ 1,289.55	\$ 226.08	\$ 104.34	\$ 129.19	\$ 135.65	\$ 117.95	\$ 15,474.60	\$ 2,712.96
	ABC 1 W/20% 3-TIER RX MM \$1500/\$3000	F	\$ 1,885.73	\$ 1,681.70	\$ 204.03	\$ 94.17	\$ 116.59	\$ 122.42	\$ 106.45	\$ 20,180.40	\$ 2,448.36
ABC 2 W/20% 3-TIER RX \$2K/\$4K DED	S	\$ 644.06	\$ 616.62	\$ 27.44	\$ 12.66	\$ 15.68	\$ 16.46	\$ 14.32	\$ 7,399.44	\$ 329.28	
ABC 2 W/20% 3-TIER RX \$2K/\$4K DED	2P	\$ 1,447.28	\$ 1,289.55	\$ 157.73	\$ 72.80	\$ 90.13	\$ 94.64	\$ 82.29	\$ 15,474.60	\$ 1,892.76	
ABC 2 W/20% 3-TIER RX \$2K/\$4K DED	F	\$ 1,800.67	\$ 1,681.70	\$ 118.97	\$ 54.91	\$ 67.98	\$ 71.38	\$ 62.07	\$ 20,180.40	\$ 1,427.64	