Blue Cross Blue Shield of Michigan

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 036, 037
Section Code(s): 3000, 3100, 3300, 3400
PPO - Flexible Blue 2, RX6
Effective Date: 01/01/2018
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.	$1,350 per member $2,700 per family	$2,700 per member $5,400 per family
Copays • Fixed Dollar Copays	No Copay	No Copay
Coinsurance • Percent Coinsurance	0%	20% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums The full family out of pocket maximum must be met before it is considered satisfied.	$2,300 per member $4,600 per family Includes Deductible, Coinsurance and Copays	$4,500 per member $9,000 per family Includes Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year	Covered - 100%	Covered - 80% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate specific antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams one per calendar year	Covered - 100%	Covered - 80% after deductible
Well Child Care • 8 visits per calendar year, birth through 12 months • 6 visits per calendar year, 13 months through 35 months • 2 visits per calendar year, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after deductible	Covered - 80% after deductible
Online Visits Note: Services are payable when rendered by American Well or BCBS providers	Covered - 100% after deductible	Covered - 80% after deductible
Office Consultations	Covered - 100% after deductible	Covered - 80% after deductible
Pre-Surgical Consultations	Covered - 100% after deductible	Covered - 80% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after deductible	Covered - 100% after deductible
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Urgent Care Services	Covered - 100% after deductible	Covered - 80% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 100% after deductible	Covered - 100% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 100% after deductible	Covered - 80% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 100% after deductible	Covered - 80% after deductible
Radiation Therapy and Chemotherapy	Covered - 100% after deductible	Covered - 80% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal Care Visits	Covered - 100%	Covered - 80% after deductible
Postnatal Care Visits	Covered - 100% after deductible	Covered - 80% after deductible
Delivery and Nursery Care	Covered - 100% after deductible	Covered - 80% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 100% after deductible	Covered - 80% after deductible
Inpatient Medical Care	Covered - 100% after deductible	Covered - 80% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100% after deductible	Covered - 100% after deductible
Home Health Care	Covered - 100% after deductible	Covered - 100% after deductible
Skilled Nursing Limited to a maximum of 90 days per calendar year	Covered - 100% after deductible	Covered - 100% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 100% after deductible	Covered - 80% after deductible
Bariatric Surgery	Covered - 100% after deductible	Covered - 80% after deductible
Oral Surgery Wisdom teeth extractions	Covered - 100% after deductible	Covered - 100% after in-network deductible
Sterilization - males only excludes reversal sterilization	Covered - 100% after deductible	Covered - 80% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 80% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100% after deductible	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 100% after deductible	Covered - 80% after deductible

Behavioral Health Care and Substance Abuse Treatment Services

Benefits	In-Network	Out-of-Network
Inpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 100% after deductible	Covered - 80% after deductible
Outpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 100% after deductible	Covered - 80% after deductible
• Online Behavioral Health Visits	Covered - 100% after deductible	Covered - 80% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

Benefits	In-Network	Out-of-Network
Applied Behavioral Analysis (ABA) Pre-authorization required **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 100% after deductible	Covered - 80% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 100% after deductible	Covered - 80% after deductible
Nutritional Counseling	Covered - 100% after deductible	Covered - 80% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 100% after deductible	Covered - 80% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 24 visits per calendar year	Covered - 100% after deductible	Covered - 80% after deductible
Durable Medical Equipment	Covered - 100% after deductible	Covered - 80% after deductible
Prosthetic and Orthotic Devices	Covered - 100% after deductible	Covered - 80% after deductible
Private Duty Nursing Care	Covered - 80% after deductible	Covered - 80% after deductible
Allergy Testing and Therapy	Covered - 100% after deductible	Covered - 80% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 100% after deductible	Covered - 80% after deductible

Note: The following services require preapproval: Inpatient Care, select Radiology and Diagnostic Services, Inpatient Behavioral Health Care and Substance Abuse Treatment, and Skilled Nursing.

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Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 036, 037
Section Code(s): 3000, 3100, 3300, 3400
Prescription Drugs
Effective Date: 01/01/2018
Benefits-at-a-glance

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BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Deductible	$1,350 per individual $2,700 per family
Retail - 30 day supply	$10 copay after deductible - Generic drugs $40 copay after deductible - Brand drugs $0 copay after deductible – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D) Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 80% of the approved amount, less the member's copay.
Mail Order - 90 day supply	$20 copay after deductible - Generic drugs $80 copay after deductible - Brand drugs
Specialty Drugs – 30 day supply Retail and Mail Order	$10 copay after deductible - Generic drugs $40 copay after deductible - Brand drugs Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered
Diabetic Supplies	Not Covered

Features of your prescription drug plan	
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

VSP-3 Plus Benefits

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In-network providers

When you see a MESSA VSP in-network provider for services that are covered charges (exam, lenses and frame allowance, or exam and contact lenses), the provider bills VSP directly for the covered charges. If the cost of the frames or contact lenses exceeds the maximum benefit allowance specified in the chart below, the member will have to pay the provider directly for excess costs. A directory of MESSA VSP in-network providers is available on the web at **www.messa.org** > Members > Find a Doctor > VSP Vision (Find an Eye Doctor).

Out-of-network providers

(Maximum reimbursement to patient)

Out-of-network providers are providers who do not participate with MESSA's VSP plan. Benefits for examinations, lenses or frames that are obtained from an out-of-network provider are subject to a maximum reimbursement. Members and dependents who choose to see an out-of-network provider must pay the provider and submit an itemized receipt to VSP for reimbursement. The member is responsible for the difference. The reimbursement will be limited to the maximum amount for each covered charge as indicated in the chart below.

Features	VSP-3 Plus In-network provider	VSP-3 Plus Out-of-network provider
Exam		
■ Optometrist	No copayment	$35 maximum reimbursement
■ Ophthalmologist		$45 maximum reimbursement
Contact lens allowance (includes exam)		
■ Cosmetic (elective)	Covered in full	$150 maximum reimbursement
■ Disposable	$200	
Frame allowance	**$80**	**$66 maximum reimbursement**
Lenses		
■ Single vision	Covered	$38 maximum reimbursement
■ Bifocal		$60 maximum reimbursement
■ Trifocal		$72 maximum reimbursement
■ Lenticular		$108 maximum reimbursement
Extra lens features		
■ Pink #1 or #2 tint	Covered	Patient pays for all materials and services above maximum reimbursement amount.
■ Rimless		
■ Oversize		
■ Blended		
■ Progressive		
Tinted		
● Tinted single vision	Covered	$42 maximum reimbursement
● Tinted bifocal		$70 maximum reimbursement
● Tinted trifocal		$84 maximum reimbursement
● Tinted lenticular		$118 maximum reimbursement
Polarized		
● Polarized single vision	Covered	$56 maximum reimbursement
● Polarized bifocal		$90 maximum reimbursement
● Polarized trifocal		$110 maximum reimbursement
● Polarized lenticular		$138 maximum reimbursement

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MESSA Dental Plan Benefit Highlights

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MESSA Account: Oakridge Public Schools **Effective Date:**

Employee Group: Non-Affiliated **Group/Subgroup:** 6056-0033

Plan Guidelines

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.

Diagnostic & Preventive Services 80 %	Basic Services 80 %	Major Services 80 %	Orthodontics 80 %
• Oral Examination • Prophylaxes • Topical Fluoride* • Brush Biopsy • Emergency Palliative • Two Cleanings in 12 Months **RIDER** (If neither box below is checked, you do not have this coverage.) ☐ 3 Cleanings in 12 Months ☐ 4 Cleanings in 12 Months **Fluoride treatments are payable twice in any period of 12 consecutive months for people up to age 19.*	• 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. * Bitewing x-rays are payable once in any period of 12 consecutive months. Full mouth panograph is payable once in 5 years. ** Payable once in any five-year period on the same tooth. **RIDER** (If the box below is not checked, you do not have this coverage.) ☑ Sealants — payable on occlusal surface of first permanent molars for patients up to age nine and for second permanent molars for patients up to age 14 that are free from caries and restorations.	• Procedures for the construction of fixed bridgework, endosteal implants, partial and complete dentures. • Payable once in any 5 year period for the same appliances.	• 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. **RIDER** (If the box below is not checked, you do not have this coverage.) ☐ Adult orthodontics: removes the age 19 restriction on Orthodontics coverage.
$ 1,000 annual maximum per person **Diagnostic & Preventive Services, Basic Services, and Major Services**			$ 1,300 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.

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VSP-3 Plus Benefits

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In-network providers

When you see a MESSA VSP in-network provider for services that are covered charges (exam, lenses and frame allowance, or exam and contact lenses), the provider bills VSP directly for the covered charges. If the cost of the frames or contact lenses exceeds the maximum benefit allowance specified in the chart below, the member will have to pay the provider directly for excess costs. A directory of MESSA VSP in-network providers is available on the web at **www.messa.org** > Members > Find a Doctor > VSP Vision (Find an Eye Doctor).

Out-of-network providers

(Maximum reimbursement to patient)

Out-of-network providers are providers who do not participate with MESSA's VSP plan. Benefits for examinations, lenses or frames that are obtained from an out-of-network provider are subject to a maximum reimbursement. Members and dependents who choose to see an out-of-network provider must pay the provider and submit an itemized receipt to VSP for reimbursement. The member is responsible for the difference. The reimbursement will be limited to the maximum amount for each covered charge as indicated in the chart below.

Features	VSP-3 Plus In-network provider	VSP-3 Plus Out-of-network provider
Exam		
■ Optometrist	No copayment	$35 maximum reimbursement
■ Ophthalmologist		$45 maximum reimbursement
Contact lens allowance (includes exam)		
■ Cosmetic (elective)	Covered in full	$150 maximum reimbursement
■ Disposable	$200	
Frame allowance	**$80**	**$66 maximum reimbursement**
Lenses		
■ Single vision	Covered	$38 maximum reimbursement
■ Bifocal		$60 maximum reimbursement
■ Trifocal		$72 maximum reimbursement
■ Lenticular		$108 maximum reimbursement
Extra lens features		
■ Pink #1 or #2 tint	Covered	Patient pays for all materials and services above maximum reimbursement amount.
■ Rimless		
■ Oversize		
■ Blended		
■ Progressive		
Tinted	Covered	
● Tinted single vision		$42 maximum reimbursement
● Tinted bifocal		$70 maximum reimbursement
● Tinted trifocal		$84 maximum reimbursement
● Tinted lenticular		$118 maximum reimbursement
Polarized	Covered	
● Polarized single vision		$56 maximum reimbursement
● Polarized bifocal		$90 maximum reimbursement
● Polarized trifocal		$110 maximum reimbursement
● Polarized lenticular		$138 maximum reimbursement

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www.messa.org

MESSA Group Term Life Insurance Benefit Highlights

MESSA Group Term Life Insurance Benefit Highlights

MESSA Account: Oakridge Public Schools

Employee Group: Non-Affiliated

Effective Date:

This is a brief summary of your coverage available under MESSA's Group Term Life and AD&D policy. Please refer to your Life & Accident Insurance Certificate Booklet for complete information.

Feature	Definition	Your Coverage
Group Term Life Insurance	The amount of your Group Term Life Insurance coverage.	$ 45,000
Group AD&D Insurance	The amount of your Accidental Death and Dismemberment (AD&D) coverage.	$ 45,000
Group Dependent Term Life Insurance: SPOUSE	This provides a life benefit equal to 50% of the member's benefit (not to exceed $25,000) for the spouse and does not contain AD&D benefits.	$ N/A
Group Dependent Term Life Insurance: CHILD(REN)	This provides a life benefit equal to 25% of the member's benefit (not to exceed $12,500) for all eligible children and does not contain AD&D benefits.	$ N/A

It is important to note that Group Term Life Insurance in excess of $50,000 and Group Dependent Term Life Insurance (if the benefit exceeds $2,000) are taxable benefits.

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MESSA Group LTD Benefit Highlights

Underwritten by Life Insurance Company of North America

MESSA Account: Oakridge Public Schools Employee Group: Non-Affiliated

Effective Date: _____

Long Term Disability (LTD) insurance provides benefits at a percentage of a member's salary in the event of total disability. Benefits begin after the satisfaction of a waiting period and continue as long as the member remains totally disabled as described under "Maximum Benefit Period" in the LTD certificate booklet. ***This is a brief summary of your coverage available under MESSA's Group LTD insurance. Refer to the actual certificate booklet for complete information.***

Feature	Definition	Your Coverage
Pre-Existing Conditions Waived	Medical conditions for which the advice or treatment was received prior to effective date of coverage are included. However, doctor-verified disabilities in effect prior to the effective date would be excluded.	Yes
Waiting Period	*Calendar Day (CD)*: The waiting period is based on actual calendar days. *Work Day (WD)*: The waiting period is based on the consecutive number of contracted work days. *Modified Fill (MF)*: Benefits begin on the latter of exhaustion of sick time/ bank or the specified number of calendar/work day waiting period. *Straight Wait (SW)*: Benefits begin after the specified number of calendar/ work day waiting period.	60 CDMF
Benefit Level	Percent of covered salary.	66 2/3%
Maximum Benefit Level	Monthly benefit up to the maximum amount bargained.	5,000.00
Minimum Maximum Benefit	There is a minimum monthly benefit of 5% of the gross monthly benefit or $50, whichever is greater, after all offsets are applied, not to exceed the maximum monthly benefit.	5%
Offsets	Benefits are reduced by any income the employee receives or is entitled to receive such as vacation pay, salary continuation, workers' compensation, full auto wage loss benefit, any employer-paid group plan, retirement benefits you receive from your employer's retirement or pension plan, including Michigan Public School Employees Retirement System (MPSERS), short-term disability, and others.	
Social Security Offsets	*Primary:* Social security retirement and social security disability are offsets. *Family:* Any social security disability benefits received by the employee's family due to the employee's disability is an offset.	Family
Freeze on Offsets	Monthly disability benefits will not be reduced because of automatic, statutory or general cost of living increases in income from other sources after MESSA's initial benefit determination for each specified offset has been made. The exception to this is an unsuccessful return to work with increased salary, social security and retirement cost of living.	Yes
COLA	An employee's benefit may be increased while on claim due to increase in the cost of living. The increase is based on changes in the Consumer Price Index as of January 1 each year and is payable on the anniversary of the commencement of benefit payment. There is a maximum annual increase of 3%.	No
Own Occupation Maximum Benefit Period	Disability benefits may be payable during continuous disability. After the own occupation period, a member must be unable to perform any occupation for which he/she is qualified by training, experience or education. Benefits may be payable up to age 65. For benefits commencing at or after age 60, please see your benefit schedule.	2 years
Mental / Nervous Conditions	These conditions are covered as any other illness unless you have a 2-year aggregate limitation.	Same as any other illness
Alcoholism / Drug Abuse	These conditions are covered as any other illness unless you have a 2-year aggregate limitation.	Same as any other illness

For additional information please call MESSA's Disability Department at 800.247.6951.

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