The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.messa.org or call MESSA at 800-336-0013. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call MESSA at 800-336-0013 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-Network: $500 Individual/ $1,000 Family</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Out-of-Network: $1,000 Individual/ $2,000 Family</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
<td></td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care services are covered before you meet your deductible.</td>
<td></td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td></td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)</td>
<td>In-Network: $1,500 Individual/ $3,000 Family</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>Out-of-Network: $3,000 Individual/ $6,000 Family</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
<td></td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn’t cover.</td>
<td></td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. For a list of network providers see <a href="http://www.messa.org">www.messa.org</a> or call MESSA at 800-336-0013.</td>
<td></td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>You can see the specialist you choose without a referral.</td>
<td></td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury</td>
<td><strong>In-Network Provider</strong> (You will pay the least) $20 copay/office visit 20%</td>
<td>Copay is waived if seen on same date of injury.</td>
</tr>
<tr>
<td></td>
<td>or illness</td>
<td>coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most) $20 copay/visit 20%</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>screening/ immunization</td>
<td><strong>No charge; deductible does not apply</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Not Covered</strong></td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td><strong>No charge</strong></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td><strong>20% coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic or prescribed</td>
<td>**$10 copay/prescription for retail 34-day supply, $20 copay/prescription for</td>
<td>Preventive drugs covered in full. Your prescription</td>
</tr>
<tr>
<td></td>
<td>over-the-counter drugs</td>
<td>90-day supply; deductible does not apply</td>
<td>drug coverage has a separate out-of-pocket limit of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>**$10 copay/prescription for retail 34-day supply, $20 copay/prescription for</td>
<td>$1,000/$2,000. Mail order drugs are not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>90-day supply plus an additional 25% of BCBSM approved amount for the drug;</td>
<td>out-of-network.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand-name drugs</td>
<td>**$40 copay/prescription for retail 34-day supply, $80 copay/prescription for</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>90-day supply; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>**$40 copay/prescription for retail 34-day supply, $80 copay/prescription for</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>90-day supply plus an additional 25% of BCBSM approved amount for the drug;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Preferred brand-name drugs</td>
<td>**$40 copay/prescription for retail 34-day supply, $80 copay/prescription for</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>90-day supply; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>**$40 copay/prescription for retail 34-day supply, $80 copay/prescription for</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>90-day supply plus an additional 25% of BCBSM approved amount for the drug;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>deductible does not apply</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery</td>
<td><strong>No charge</strong></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>center)</td>
<td><strong>20% coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(You will pay the least)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>$50 copay/visit</td>
<td>$50 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 copay/visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance use disorder services</td>
<td>Outpatient services</td>
<td>$20 copay/visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge; deductible does not apply</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------</td>
<td>----------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>No charge</td>
<td>Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</td>
<td>No charge</td>
<td>Preauthorization is required. Unlimited visits.</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
### Excluded Services & Other Covered Services:

#### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight Loss programs

#### Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See [www.messa.org](http://www.messa.org)
- Hearing Aids
- If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or coinsurance, or benefits not otherwise covered.
- Infertility treatment
- Non-Emergency care when travelling outside the U.S.
- Private-duty nursing
Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor’s Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling 1-800-324-6172. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact MESSA by calling 800-336-0013.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or http://www.michigan.gov/difs or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? Yes.

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: See Addendum

--------------------To see examples of how this plan might cover costs for a sample medical situation, see the next section.--------------------
### About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments, and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

---

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: $500
- Specialist copayment: $20
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

Total Example Cost: $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$120</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn't covered:
- Limits or exclusions: $0
The total Peg would pay is: $620

---

**Managing Joe’s Type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $500
- Specialist copayment: $20
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

Total Example Cost: $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$990</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn't covered:
- Limits or exclusions: $0
The total Joe would pay is: $1,490

---

**Mia’s Simple Fracture**  
(in-network emergency room visit and follow up care)

- The plan’s overall deductible: $500
- Specialist copayment: $20
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic tests (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total Example Cost: $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$190</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn't covered:
- Limits or exclusions: $0
The total Mia would pay is: $690

---

The plan would be responsible for the other costs of these EXAMPLE covered services.
Language services

If you, or someone you’re helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call MESSA’s Member Service Center at 800.336.0013 or TTY 888.445.5614.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de servicios para miembros de MESSA, que aparece en la parte trasera de su tarjeta.

Ukoliko vama bilo nekoje pomoć ili informaciju potrebna, imate pravo dobiti pomoć i informaciju na vašem jeziku bezplatno. Da biste razgovarali sa prevodicom, pozovite broj za ulsuge članova MESSA na zadnjoj strani vaše kartice.

If you need help filing a grievance, MESSA’s general counsel is available to help you. If you believe that MESSA or BCBSM failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, or by mail, phone, fax or email: General Counsel, MESSA, P.O. Box 2560, East Lansing, MI 48826-2560, 800.292.4910, TTY: 888.445.5613, fax: 517.203.2909 or CivilRights- GeneralCounsel@messa.org. You can also file a civil rights complaint with the Office for Civil Rights on the web at OCRComplaint@hhs.gov or by mail, phone or email: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, 800.368.1019, TTD: 800.537.7697, or OCRComplaint@hhs.gov.

Important disclosure

MESSA and Blue Cross Blue Shield of Michigan (BCBSM) comply with federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. MESSA and BCBSM provide free auxiliary aids and services to people with disabilities to communicate effectively with us, including qualified sign language interpreters. If you need assistance, call MESSA’s Member Service Center at 800.336.0013 or TTY 888.445.5614.

Important disclosure

MESSA and Blue Cross Blue Shield of Michigan (BCBSM) comply with federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. MESSA and BCBSM provide free auxiliary aids and services to people with disabilities to communicate effectively with us, including qualified sign language interpreters. If you need assistance, call MESSA’s Member Service Center at 800.336.0013 or TTY 888.445.5614.

Important disclosure

MESSA and Blue Cross Blue Shield of Michigan (BCBSM) comply with federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. MESSA and BCBSM provide free auxiliary aids and services to people with disabilities to communicate effectively with us, including qualified sign language interpreters. If you need assistance, call MESSA’s Member Service Center at 800.336.0013 or TTY 888.445.5614.
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.messa.org or call MESSA at 800-336-0013. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call MESSA at 800-336-0013 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-Network: $500 Individual/$1,000 Family</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: $1,000 Individual/$2,000 Family</td>
<td></td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care services are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network: $2,500 Individual/$5,000 Family</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>(May include a coinsurance maximum)</td>
<td>Out-of-Network: $5,000 Individual/$10,000 Family</td>
<td></td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. For a list of network providers see <a href="http://www.messa.org">www.messa.org</a> or call MESSA at 800-336-0013.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 copay/office visit</td>
<td>30% coinsurance</td>
<td>Copay is waived if seen on same date of injury.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 copay/visit</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No charge; deductible does not apply</td>
<td>Not Covered</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>May require preauthorization.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic or prescribed over-the-counter drugs</td>
<td>$10 copay/prescription for retail 34-day supply, $20 copay/prescription for 90-day supply; deductible does not apply</td>
<td>$10 copay/prescription for retail 34-day supply plus an additional 25% of BCBSM approved amount for the drug; deductible does not apply</td>
<td>Preventive drugs covered in full. Your prescription drug coverage has a separate out-of-pocket limit of $1,000/$2,000. Mail order drugs are not covered out-of-network.</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.messa.org">www.messa.org</a></td>
<td>Preferred brand-name drugs</td>
<td>$40 copay/prescription for retail 34-day supply, $80 copay/prescription for 90-day supply; deductible does not apply</td>
<td>$40 copay/prescription for retail 34-day supply plus an additional 25% of BCBSM approved amount for the drug; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Preferred brand-name drugs</td>
<td>$40 copay/prescription for retail 34-day supply, $80 copay/prescription for 90-day supply; deductible does not apply</td>
<td>$40 copay/prescription for retail 34-day supply plus an additional 25% of BCBSM approved amount for the drug; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate emergency care</td>
<td>Emergency room care</td>
<td>$50 copay/visit</td>
<td>$50 copay/visit</td>
<td>Copay waived if admitted or accidental injury.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>-------------------------------------------</td>
<td>------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>medical attention</td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ultradian care</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance use disorder services</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge; deductible does not apply</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

- Mileage limits apply.
- Preauthorization may be required.
- None
- Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. Cost sharing does not apply to certain maternity services considered to be preventive.
- Physical, Occupational, Speech therapy is limited to a combined maximum of 60 visits per member, per calendar year.
- Applied behavioral analysis (ABA) treatment for Autism – when rendered by an approved board-certified analyst – is covered through age 18, subject to preauthorization.
- Preauthorization is required. Limited to a maximum of 120 days per member, per calendar year.
- Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
- Preauthorization is required. Unlimited visits.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
### Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) |
|---|---|---|
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care (Adult) | • Routine eye care (Adult) | • Weight Loss programs |

| Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.) |
|---|---|---|
| • Acupuncture | • Coverage provided outside the United States. See [www.messa.org](http://www.messa.org) |
| • Bariatric surgery | • Hearing Aids |
| • Chiropractic care | • If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or coinsurance, or benefits not otherwise covered. |
| | | • Infertility treatment |
| | | • Non-Emergency care when travelling outside the U.S. |
| | | • Private-duty nursing |
Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor’s Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling 1-800-324-6172. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact MESSA by calling 800-336-0013.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or http://www.michigan.gov/difs or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? Yes.

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: See Addendum

-----------------------------To see examples of how this plan might cover costs for a sample medical situation, see the next section.-----------------------------
### About these Coverage Examples:

*This is not a cost estimator.* Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

---

#### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan’s overall deductible**: $500
- **Specialist copayment**: $20
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

This **EXAMPLE** event includes services like:
- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

**Total Example Cost**: $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$120</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$950</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0

**The total Peg would pay is**: $1,570

---

#### Managing Joe’s Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan’s overall deductible**: $500
- **Specialist copayment**: $20
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

This **EXAMPLE** event includes services like:
- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

**Total Example Cost**: $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$990</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$140</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0

**The total Joe would pay is**: $1,630

---

#### Mia’s Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan’s overall deductible**: $500
- **Specialist copayment**: $20
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

This **EXAMPLE** event includes services like:
- Emergency room care (*including medical supplies*)
- Diagnostic tests (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

**Total Example Cost**: $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$190</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$60</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0

**The total Mia would pay is**: $750

---

The plan would be responsible for the other costs of these **EXAMPLE** covered services.
**Important disclosure**

MESSA and Blue Cross Blue Shield of Michigan (BCBSM) comply with federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. MESSA and BCBSM provide free auxiliary aids and services to people with disabilities to communicate effectively with us, including qualified sign language interpreters. If you need assistance, call MESSA’s Member Service Center at 800.336.0013 or TTY 888.445.5614.

If you need help filing a grievance, MESSA’s general counsel is available to help you. If you believe that MESSA or BCBSM failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, phone, fax or email:

General Counsel, MESSA, P.O. Box 2560, East Lansing, MI 48826-2560, 800.292.4910, TTY: 888.445.5613, fax: 517.203.2909 or CivilRights-GeneralCounsel@messa.org.

You can also file a civil rights complaint with the Office for Civil Rights on the web at [OCRComplaint@hhs.gov](http://OCRComplaint@hhs.gov), or by mail, phone or email: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, 800.368.1019, TTD: 800.537.7697, or [OCRComplaint@hhs.gov](http://OCRComplaint@hhs.gov).
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.messa.org or call MESSA at 800-336-0013. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call MESSA at 800-336-0013 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-Network: $1,000 Individual/ $2,000 Family</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: $2,000 Individual/ $4,000 Family</td>
<td></td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care services are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network: $2,000 Individual/ $4,000 Family</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>(May include a coinsurance maximum)</td>
<td>Out-of-Network: $4,000 Individual/ $8,000 Family</td>
<td></td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. For a list of network providers see <a href="http://www.messa.org">www.messa.org</a> or call MESSA at 800-336-0013.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 copay/office visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No charge; deductible does not apply</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic or prescribed over-the-counter drugs</td>
<td>$10 copay/prescription for retail 34-day supply, $20 copay/prescription for 90-day supply; deductible does not apply</td>
<td>$10 copay/prescription for retail 34-day supply plus an additional 25% of BCBSM approved amount for the drug; deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Preferred brand-name drugs</td>
<td>$40 copay/prescription for retail 34-day supply, $80 copay/prescription for 90-day supply; deductible does not apply</td>
<td>$40 copay/prescription for retail 34-day supply plus an additional 25% of BCBSM approved amount for the drug; deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred brand-name drugs</td>
<td>$40 copay/prescription for retail 34-day supply, $80 copay/prescription for 90-day supply; deductible does not apply</td>
<td>$40 copay/prescription for retail 34-day supply plus an additional 25% of BCBSM approved amount for the drug; deductible does not apply</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>If you need immediate care</strong></td>
<td>Emergency room care</td>
<td>$50 copay/visit</td>
<td>$50 copay/visit</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>Medical attention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
<td>Mileage limits apply.</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$25 copay/visit</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>In-Network Provider (You will pay the least)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Network Provider (You will pay the most)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>Preauthorization may be required.</td>
</tr>
<tr>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance use disorder services</td>
<td>Outpatient services</td>
<td>$20 copay/visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>Preauthorization is required.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visits</td>
<td>No charge; deductible does not apply</td>
<td>20% coinsurance</td>
<td>Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. Cost sharing does not apply to certain maternity services considered to be preventive.</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>No charge</td>
<td>No charge</td>
<td>Preauthorization is required.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>Physical, Occupational, Speech therapy is limited to a combined maximum of 60 visits per member, per calendar year.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>Applied behavioral analysis (ABA) treatment for Autism – when rendered by an approved board-certified analyst – is covered through age 18, subject to preauthorization.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>No charge</td>
<td>Preauthorization is required. Limited to a maximum of 120 days per member, per calendar year.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>No charge</td>
<td>Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</td>
<td>No charge</td>
<td>Preauthorization is required. Unlimited visits.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------------------------------------</td>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Long-term care
- Routine foot care
- Dental care (Adult)
- Routine eye care (Adult)
- Weight Loss programs
- Long-term care
- Routine eye care (Adult)
- Weight Loss programs

### Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See [www.messa.org](http://www.messa.org)
- Hearing Aids
- Infertility treatment
- Non-Emergency care when travelling outside the U.S.
- If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses — like the deductible, copayments, or coinsurance, or benefits not otherwise covered.
- Private-duty nursing
Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:
Department of Labor’s Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling 1-800-324-6172. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact MESSA by calling 800-336-0013.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P.O. Box 30220, Lansing, MI 48909-7720 or http://www.michigan.gov/difs or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? Yes.
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.
(IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: See Addendum

________________________To see examples of how this plan might cover costs for a sample medical situation, see the next section.________________________
**About these Coverage Examples:**

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments, and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s Type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>- The plan’s overall deductible</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>- Specialist copayment</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>- Hospital (facility) coinsurance</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>- Other coinsurance</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

This EXAMPLE event includes services like:
- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

This EXAMPLE event includes services like:
- Emergency room care (*including medical supplies*)
- Diagnostic tests (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,700</th>
<th>$7,400</th>
<th>$1,900</th>
</tr>
</thead>
</table>

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$120</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered:

| Limits or exclusions | $0 |

The total Peg would pay is $1,120

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$990</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered:

| Limits or exclusions | $0 |

The total Joe would pay is $1,990

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$190</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered:

| Limits or exclusions | $0 |

The total Mia would pay is $1,190

The plan would be responsible for the other costs of these EXAMPLE covered services.
Language services

If you, or someone you’re helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call MESSA’s Member Service Center at 800.336.0013 or TTY 888.445.5614.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de servicios para miembros de MESSA, que aparece en la parte trasera de su tarjeta.

If you, or those you are assisting, need help and information in your language at no cost, call MESSA’s Member Service Center at 800.336.0013 or TTY 888.445.5614.

If you or the person you are helping need assistance in your language, you have the right to receive help and information in your language at no cost. Call MESSA’s Member Service Center at 800.336.0013 or TTY 888.445.5614.

Important disclosure

MESSA and Blue Cross Blue Shield of Michigan (BCBSM) comply with federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. MESSA and BCBSM provide free auxiliary aids and services to people with disabilities to communicate effectively with us, including qualified sign language interpreters. If you need assistance, call MESSA’s Member Service Center at 800.336.0013 or TTY 888.445.5614.

If you need help filing a grievance, MESSA’s general counsel is available to help you. If you believe that MESSA or BCBSM failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, phone, fax or email: General Counsel, MESSA, P.O. Box 2560, East Lansing, MI 48826-2560, 800.292.4910, TTY: 888.445.5613, fax: 517.203.2909 or CivilRights-GeneralCounsel@messa.org. You can also file a civil rights complaint with the Office for Civil Rights on the web at OCRComplaint@hhs.gov or by mail, phone or email: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, 800.368.1019, TTD: 800.537.7697, or OCRComplaint@hhs.gov.
**Important Questions** | **In-Network** | **Out-of-Network** | **Why This Matters:**
---|---|---|---
What is the overall deductible? | $1,000 Individual/ $2,000 Family | $2,000 Individual/ $4,000 Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible? | Yes. Preventive care services are covered before you meet your deductible. | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/).
Are there other deductibles for specific services? | No. | | You don’t have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? (May include a coinsurance maximum) | $3,000 Individual/ $6,000 Family | $6,000 Individual/ $12,000 Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit? | Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit.
Will you pay less if you use a network provider? | Yes. For a list of network providers see [www.messa.org](http://www.messa.org) or call MESSA at 800-336-0013. | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider. and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral.
### Common Medical Event

**Services You May Need**

<table>
<thead>
<tr>
<th>Event</th>
<th>Services</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 copay/office visit</td>
<td>30% coinsurance</td>
<td>Copay is waived if seen on same date of injury.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 copay/visit</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge; deductible does not apply</td>
<td>Not Covered</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>May require preauthorization.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic or prescribed over-the-counter drugs</td>
<td>$10 copay/prescription for retail 34-day supply, $20 copay/prescription for 90-day supply; deductible does not apply</td>
<td>$10 copay/prescription for retail 34-day supply plus an additional 25% of BCBSM approved amount for the drug; deductible does not apply</td>
<td>Preventive drugs covered in full. Your prescription drug coverage has a separate out-of-pocket limit of $1,000/$2,000. Mail order drugs are not covered out-of-network.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand-name drugs</td>
<td>$40 copay/prescription for retail 34-day supply, $80 copay/prescription for 90-day supply; deductible does not apply</td>
<td>$40 copay/prescription for retail 34-day supply plus an additional 25% of BCBSM approved amount for the drug; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Preferred brand-name drugs</td>
<td>$40 copay/prescription for retail 34-day supply, $80 copay/prescription for 90-day supply; deductible does not apply</td>
<td>$40 copay/prescription for retail 34-day supply plus an additional 25% of BCBSM approved amount for the drug; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate care</td>
<td>Emergency room care</td>
<td>$50 copay/visit</td>
<td>$50 copay/visit</td>
<td>Copay waived if admitted or accidental injury.</td>
</tr>
</tbody>
</table>

*Note: All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.*
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>medical attention</td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 copay/visit</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance use disorder services</td>
<td>Outpatient services</td>
<td>$20 copay/visit</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge; deductible does not apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children's eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
### Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.):**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight Loss programs

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.):**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See [www.messa.org](http://www.messa.org)
- Hearing Aids
- Infertility treatment
- Non-Emergency care when travelling outside the U.S.
- Private-duty nursing
- If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or coinsurance, or benefits not otherwise covered.
Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor’s Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling 1-800-324-6172. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact MESSA by calling 800-336-0013.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or http://www.michigan.gov/difs or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? Yes.

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: See Addendum

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan’s overall deductible**: $1,000
- **Specialist copayment**: $20
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

This EXAMPLE event includes services like:
- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

**Total Example Cost**: $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$120</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,140</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0

**The total Peg would pay is**: $2,260

### Managing Joe’s Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan’s overall deductible**: $1,000
- **Specialist copayment**: $20
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

This EXAMPLE event includes services like:
- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

**Total Example Cost**: $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$990</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$90</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0

**The total Joe would pay is**: $2,080

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan’s overall deductible**: $1,000
- **Specialist copayment**: $20
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

This EXAMPLE event includes services like:
- Emergency room care (*including medical supplies*)
- Diagnostic tests (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

**Total Example Cost**: $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$190</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0

**The total Mia would pay is**: $1,200
Language services

If you, or someone you’re helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call MESSA’s Member Service Center at 800.336.0013 or TTY 888.445.5614.

If usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de servicios para miembros de MESSA, que aparece en la parte trasera de su tarjeta.

Ukolio je vama ili nekom kome pomažete potrebna pomoć, imate pravo dobiti pomoć i informaciju na vašem jeziku besplatno. Da biste razgovarali sa prevodiocem, pozovite broj za uluge članova MESSA na zadnjoj strani vaše kartice.

Important disclosure

MESSA and Blue Cross Blue Shield of Michigan (BCBSM) comply with federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. MESSA and BCBSM provide free auxiliary aids and services to people with disabilities to communicate effectively with us, including qualified sign language interpreters. If you need assistance, call MESSA’s Member Service Center at 800.336.0013 or TTY 888.445.5614.

If you need help filing a grievance, MESSA’s general counsel is available to help you. If you believe that MESSA or BCBSM failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, phone, fax or email: General Counsel, MESSA, P.O. Box 2560, East Lansing, MI 48826-2560, 800.292.4910, TTY: 888.445.5613, fax: 517.203.2909 or CivilRights-GeneralCounsel@messas.org.

You can also file a civil rights complaint with the Office for Civil Rights on the web at OCRComplaint@hhs.gov, or by mail, phone or email: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, 800.368.1019, TTD: 800.537.7697, or OCRComplaint@hhs.gov.
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 contracting providers by visiting www.messa.org and using the provider directory search provided by Delta Dental.

### Plan Guidelines

- **Diagnostic & Preventive Services**: 80% Coverage
  - 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

- **Basic Services**: 80% Coverage
  - 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.
  - **RIDER** (If the box below is not checked, you do not have this coverage.)
    - Seals — 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.

- **Major Services**: 80% Coverage
  - Procedures for the construction of fixed bridgework, endosteal implants, partial and complete dentures.
  - Payable once in any 5 year period for the same appliances.

- **Orthodontics**: 80% Coverage
  - 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.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Percentage</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic &amp; Preventive Services</td>
<td>80%</td>
<td>$1,300</td>
</tr>
<tr>
<td>Basic Services</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Major Services</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Orthodontics</td>
<td>80%</td>
<td>$800</td>
</tr>
</tbody>
</table>

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

**MESSA Account:** Ferndale School District

**Employee Group:** Office Personnel

**Effective Date:** 3-1-18

**Group/Subgroup:** 0963-0008 (PAKs A, C, D & E)

#### 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](http://www.messa.org) and using the provider directory search provided by Delta Dental.

#### Diagnostic & Preventive Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coverage Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Examination</td>
<td>50%</td>
</tr>
<tr>
<td>Prophylaxes</td>
<td>50%</td>
</tr>
<tr>
<td>Topical Fluoride</td>
<td>50%</td>
</tr>
<tr>
<td>Brush Biopsy</td>
<td>50%</td>
</tr>
<tr>
<td>Emergency Palliative</td>
<td>50%</td>
</tr>
<tr>
<td>Two Cleanings in 12 Months</td>
<td>50%</td>
</tr>
</tbody>
</table>

**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.

#### Basic Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coverage Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiographs (x-rays)*</td>
<td>50%</td>
</tr>
<tr>
<td>Restorative</td>
<td>50%</td>
</tr>
<tr>
<td>Crowns**</td>
<td>50%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>50%</td>
</tr>
<tr>
<td>Endodontic Services — treatment for diseased or damaged nerves.</td>
<td>50%</td>
</tr>
<tr>
<td>Periodontic Services — treatment for diseases of the gum and teeth-supporting structures.</td>
<td>50%</td>
</tr>
</tbody>
</table>

* Bitewing x-rays are payable once in any period of 12 consecutive months. Full mouth panograph is payable once in 5 years.

**RIDER**
(If the box below is not checked, you do not have this coverage.)

- [ ] Sealsants — 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.

#### Major Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coverage Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedures for the construction of fixed bridgework, endoestal implants, partial and complete dentures.</td>
<td>50%</td>
</tr>
<tr>
<td>Payable once in any 5 year period for the same appliances.</td>
<td>50%</td>
</tr>
</tbody>
</table>

#### Orthodontics

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coverage Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Necessary treatment and procedures required for the correction of abnormal bite.</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontic exam, radiographs and extractions are covered under Diagnostic &amp; Preventive Services and Basic Services.</td>
<td>50%</td>
</tr>
</tbody>
</table>

**RIDER**
(If the box below is not checked, you do not have this coverage.)

- [ ] Adult orthodontics: removes the age 19 restriction on Orthodontics coverage.

#### Benefits Caps

- **Diagnostic & Preventive Services, Basic Services, and Major Services**
  - $1,300 annual maximum per person

- **Orthodontics**
  - $500 lifetime maximum per person

For a complete listing of exclusions and limitations that apply to the plan, refer to the Delta Dental of Michigan certificate booklet.
LIFE & ACCIDENT INSURANCE
CERTIFICATE BOOKLET

GROUP INSURANCE FOR
FERNDALE SCHOOL DISTRICT

SCHOOL NUMBER 069

OFFICE PERSONNEL
The benefits for which you are insured are set forth in the pages of this booklet. Consult these pages for a further description of the terms and conditions of this coverage. Application must be made and signed by the individual before any coverage can become effective. If your plan requires contributions from you, the coverage will not become effective unless you are making the required contributions.
LIFE INSURANCE COMPANY OF NORTH AMERICA

hereby certifies that Employees of the Participating Employer indicated in the Schedule of Benefits who are insured under Group Policy No. FLI-980011 issued by Life Insurance Company of North America to

TRUSTEE OF THE NATIONAL CONSUMER INSURANCE TRUST
(Herein called the Policyholder)

are, subject to the terms and conditions of said policy, insured for the benefits described in the pages of the booklet.

This Certificate, which is furnished in accordance with, and subject to, the terms of the Group Policy, replaces any and all Certificates previously issued to you by the Insurance Company under the Group Policy specified above covering the insurance described herein. This is not the contract of insurance. Each policy and the application of the Policyholder for it constitute the entire contract. This Certificate is merely evidence of insurance provided under the Group Policy. The insurance is effective only after the person concerned is eligible for insurance and becomes and remains insured in accordance with the terms, provisions and conditions of the Group Policy.

Matthew G. Manders, President
Table of Contents

CUSTOMER PRIVACY NOTICE ...................................................................................................................... 1
  What Personal Information We Collect .................................................................................................... 1
  When We Collect It ..................................................................................................................................... 1
  Other Sources We Use ................................................................................................................................. 1
  What Personal Information We Use and Share ......................................................................................... 2
  Protection of Your Personal Information .................................................................................................. 3
  Seeing and Correcting Your Personal Information ................................................................................... 3
  Additional Rights Under Other Privacy Laws ............................................................................................ 3
  Who We Are .............................................................................................................................................. 4
  Questions or Concerns about this Privacy Notice ..................................................................................... 4

SCHEDULE OF BENEFITS ............................................................................................................................ 5

WHEN YOUR INSURANCE BEGINS ............................................................................................................... 6
  Becoming Eligible ....................................................................................................................................... 6
  Becoming Insured ...................................................................................................................................... 6

LIFE INSURANCE ........................................................................................................................................ 7
  Death Benefit ........................................................................................................................................... 7
  Protection While Disabled .......................................................................................................................... 7
  Protection After Termination ..................................................................................................................... 8

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE .................................................................. 9
  Death and Dismemberment Benefits .......................................................................................................... 9
  Not Covered ............................................................................................................................................... 9

GENERAL INFORMATION .......................................................................................................................... 10
  Beneficiary ............................................................................................................................................... 10
  Assignment of Life Insurance .................................................................................................................. 10
  Right of Recovery .................................................................................................................................... 10
  Suicide ....................................................................................................................................................... 10
  When Insurance Terminates .................................................................................................................... 10

EMPLOYEE LIFE INSURANCE ..................................................................................................................... 11
  Protection after Termination ..................................................................................................................... 11

GENERAL PROVISIONS APPLICABLE TO ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE .... 12
  Notice of Claim ......................................................................................................................................... 12
  Proof of Claim .......................................................................................................................................... 12
  Examinations ........................................................................................................................................... 12
  Legal Proceedings ...................................................................................................................................... 12
  Life Insurance Company of North America .............................................................................................. 13

CLAIM PAYMENT AMENDATORY RIDER ................................................................................................. 13
  Claim Provisions ....................................................................................................................................... 13
  Administrative Provisions ........................................................................................................................ 13
Customer Privacy Notice

Privacy Notice of Cigna Corporation and its Affiliates (referred to in this notice as “we, our and us”). This privacy notice applies to our United States Operations.

We value your trust. We are committed to acting responsibly when we collect, use and protect your personal information.

Please read this privacy notice carefully. It explains the rules we at Cigna follow when we collect personal information. This notice applies to all personal information we collect about you.

Financial companies, including insurers, choose how they share your personal information. Federal and state laws say that we must tell you how we collect, share and protect your personal information.

What Personal Information We Collect

The types of information we collect, use and share depend on the product or service you have from us. It may include your:

- Name
- Telephone number
- Occupation
- Social Security number
- Address
- Date of birth
- Financial and health history
- Insurance claims information

When We Collect It

We collect your personal information when you:

- Apply for insurance
- File a claim
- Obtain services from us
- Pay premiums
- Give us your contact information

Other Sources We Use

We also collect personal information about you from others such as:

- Affiliates (Affiliates are companies related by common ownership or control)
- Other insurers
- Service providers
- Health Care Professionals
- Insurance support organizations

We may also get information from consumer reporting agencies. This might include the following records:

- Driving record
- Credit report
- Claims history with other insurers

Consumer reporting agencies may keep your information. They may disclose it to others.
## What Personal Information We Use and Share

<table>
<thead>
<tr>
<th>For everyday business purposes</th>
<th>We may share all of the personal information about you that we collect with Affiliates and nonaffiliated companies (companies that are not under common ownership with us, such as our service providers), for any purpose the law allows. For example, we may use your personal information and share it with others to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Help us run our business</td>
</tr>
<tr>
<td></td>
<td>• Process your transactions</td>
</tr>
<tr>
<td></td>
<td>• Maintain your account(s)</td>
</tr>
<tr>
<td></td>
<td>• Administer your benefit plan</td>
</tr>
<tr>
<td></td>
<td>• Respond to court orders and legal or regulatory investigations or exams</td>
</tr>
<tr>
<td></td>
<td>• Report to credit bureaus</td>
</tr>
<tr>
<td></td>
<td>• Support or improve our programs or services, including our care management and wellness programs</td>
</tr>
<tr>
<td></td>
<td>• Offer you our other products and services</td>
</tr>
<tr>
<td></td>
<td>• Do research for us</td>
</tr>
<tr>
<td></td>
<td>• Audit our business</td>
</tr>
<tr>
<td></td>
<td>• Help us prevent fraud, money laundering, terrorism and other crimes by verifying what we know about you</td>
</tr>
<tr>
<td></td>
<td>• Sell all or any part of our business or merge with another company</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>For our marketing purposes</td>
<td>We may also share your personal information with:</td>
</tr>
<tr>
<td></td>
<td>• Medical health care professionals</td>
</tr>
<tr>
<td></td>
<td>• Insurers, including reinsurers</td>
</tr>
<tr>
<td></td>
<td>• Successor insurers or claim administrators who administer your benefit plan</td>
</tr>
<tr>
<td></td>
<td>• Companies that help us recover overpayments, pay claims or do coverage reviews</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>For joint marketing with other financial companies</td>
<td>We may share your personal information with other financial companies for the purpose of joint marketing. Joint marketing is when there is a formal agreement between nonaffiliated financial companies that jointly endorse, sponsor or market financial products or services to you.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>We may also share personal information about former customers in the way described above. Federal laws don’t allow you to limit the sharing of personal information as described above.</td>
</tr>
</tbody>
</table>

Cat# 868710 © 2013 Cigna.
Protection of Your Personal Information

How do we protect your personal information?
To protect personal information from unauthorized access and use, we:
- Use reasonable security measures, including secured files, user authentication, encryption, firewall technology, and detection software
- Review the data security practices of companies we share your personal information with
- Grant access to personal information to people who must use it to do their jobs

Seeing and Correcting Your Personal Information

How can you see and correct your personal information?
Generally, you have the right to review the personal information we collect to provide you with insurance products and services if you:
- Ask us in writing
- Send the letter to the address below

When you write to us, please include your full name, address, telephone number and policy number in your letter.

If the information you ask for includes health information, we may provide the information to you through your health care provider. Due to its legal sensitivity, we won’t send you anything that we’ve collected in connection with a claim or legal proceeding.

If you believe the personal information we have is incorrect, please write to us and explain why you believe it is incorrect. If we agree with you, we will correct our records. If we disagree with you, you may send us a statement and we will include it when we give your personal information to anyone outside of Cigna.

Additional Rights Under Other Privacy Laws
You may have additional rights under state or other applicable laws.

Cat# 868710 © 2013 Cigna.
Who We Are

This privacy notice is provided by Cigna Corporation and its Affiliates:

- American Retirement Life Insurance Company
- Central Reserve Life Insurance Company
- Cigna Behavioral Health, Inc.
- Cigna Benefits Financing, Inc.
- Cigna Dental Health of California, Inc.
- Cigna Dental Health of Colorado, Inc.
- Cigna Dental Health of Delaware, Inc.
- Cigna Dental Health of Florida, Inc.
- Cigna Dental Health of Kansas, Inc.
- Cigna Dental Health of Kentucky, Inc.
- Cigna Dental Health of Maryland, Inc.
- Cigna Dental Health of Missouri, Inc.
- Cigna Dental Health of New Jersey, Inc.
- Cigna Dental Health of North Carolina, Inc.
- Cigna Dental Health of Ohio, Inc.
- Cigna Dental Health of Pennsylvania, Inc.
- Cigna Dental Health of Texas, Inc.
- Cigna Dental Health of Virginia, Inc.
- Cigna Dental Health Plan of Arizona, Inc.
- Cigna Dental Health, Inc.
- Cigna Health and Life Insurance Company
- Cigna Health Care of North Carolina, Inc.
- Cigna Health Corporation
- Cigna HealthCare Connecticut, Inc.
- Cigna HealthCare of Arizona, Inc.
- Cigna HealthCare of California, Inc.
- Cigna HealthCare of Colorado, Inc.
- Cigna HealthCare of Florida, Inc.
- Cigna HealthCare of Georgia, Inc.
- Cigna HealthCare of Illinois, Inc.
- Cigna HealthCare of Indiana, Inc.
- Cigna HealthCare of New Jersey, Inc.
- Cigna HealthCare of South Carolina, Inc.
- Cigna HealthCare of St. Louis, Inc.
- Cigna HealthCare of Tennessee, Inc.
- Cigna HealthCare of Texas, Inc.
- Cigna Life Insurance Company of New York
- Connecticut General Life Insurance Company
- Life Insurance Company of North America
- Loyal American Life Insurance Company
- Provident American Life & Health Insurance Company
- United Benefits Life Insurance Company

Questions or Concerns about this Privacy Notice

Write to us at: Cigna Corporation
Enterprise Privacy Office
P.O. Box 188014 Chattanooga,
TN 37422

Securities are offered through Cigna Benefits Financing, Inc., Member FINRA, 900 Cottage Grove Rd., A4COL, Bloomfield, CT 06002.


Cat# 868710 © 2013 Cigna.

Rev. November 7, 2013

Cat# 868710 © 2013 Cigna.
SCHEDULE OF BENEFITS
To be attached to and made part of your Certificate Booklet

Participating Employer

FERNDALE SCHOOL DISTRICT

PLAN EFFECTIVE DATE: May 1, 2018

EMPLOYEES INCLUDED: OFFICE PERSONNEL

DATE OF ELIGIBILITY: You will be eligible on the Plan Effective Date, the date of your employment, or the day following completion of the eligibility waiting period as determined by your Employer, whichever is later.

Life Insurance .................................................. $50,000

Accidental Death and Dismemberment....... $50,000
WHEN YOUR INSURANCE BEGINS

Becoming Eligible
You will be eligible for insurance as determined in accordance with the sections entitled Employees Eligible for Insurance and Date of Eligibility in the Schedule of Benefits.

Becoming Insured
If you are not required to contribute toward the cost of your insurance, you will become insured on the day you become eligible.

If you are required to pay any portion of the cost of your insurance, you will become insured on the latest of:

1. The day you become eligible, if you enroll for your insurance on or before the day you become eligible
   Or

2. The day you enroll for your insurance, if you enroll on or before the thirty-first (31st) day following the day you become eligible
   Or

3. The first day of the month following the date your evidence of insurability, to be obtained at your own expense, is approved by the Insurance Company, if you enroll for your insurance more than thirty-one (31) days following the day you become eligible

You must be actively at work on the day that your insurance is to become effective. If you are absent from work because of bodily injury or sickness on that day, you will become insured on the day you return to active work. To be considered actively at work for insurance purposes, you must be physically able to perform your normal duties for a regularly scheduled workday at the time you report to work.
LIFE INSURANCE

Death Benefit
In the event of your death from any cause, the amount of your Life Insurance as determined in accordance with the Schedule of Benefit, is payable to your beneficiary in a single sum or, if you desire, in installments. You may, at any time, change your beneficiary or the method of benefit payment.

Protection While Disabled
If, before you reach age 60 and after the effective date of your insurance but prior to your termination of school employment, you become totally disabled by bodily injury or disease so as to be prevented from engaging in any occupation for compensation or profit, your Group Life Insurance protection will be extended. Your protection will be extended up to the first anniversary of the date the total disability is approved, so long as you remain totally disabled. In order for contributions to be waived while your protection is extended, the initial proof of disability must be furnished within one year of the onset of the disability. Contributions will be waived on the first of the month coincident with or next following the date that satisfactory proof of disability is received by the Insurance Company but in no event prior to 6 months from the date the disability commenced. Your protection may be extended further, without payment of contributions, if proof of your continued total disability is submitted to the Insurance Company within the 3-month period prior to each anniversary of the date the total disability was approved.

(Note: Accidental Death and Dismemberment Insurance may not be extended in accordance with this provision.)

Contact your Employer for the forms for filing proof of your total disability within six months following onset of disability.

If you have converted your Group Life Insurance, the individual policy must be surrendered to the Insurance Company when the Insurance Company approves continuance of your Group Life Insurance protection under this provision. Any premiums paid under the individual policy will be refunded.

The amount of your insurance protection while you are so disabled will be the amount for which you were last insured under the Group Life Insurance Plan prior to your discontinuance of active work.

The Insurance Company will have the right to have its medical representative examine you when it may reasonably require, but after your Group Life Insurance protection has been extended for two full years, not more than once a year.

Proof that total disability continued to death must be submitted to the Insurance Company within one year after the date of your death. Upon receipt of that proof, the Insurance Company will pay to your beneficiary the amount of your insurance protection reduced by any amount of Group Life Insurance payable as a death benefit under any other provision of the Group Policy.

This protection will be discontinued when you are no longer so disabled, fail to submit to an examination or fail to furnish required proof, whichever occurs first. You will have the same rights on the date of the discontinuance as those described below in “Protection After Termination,” unless you become insured again under the Group Insurance Plan.
Protection After Termination

1. If your Group Life Insurance terminates because you leave school employment or because of your termination of membership in the class or classes of employees insured under the Group Policy, you may, within sixty-two (62) days after such termination of insurance, make application for any type of Individual Life Insurance policy then customarily issued by the Insurance Company (except a policy of term insurance, a policy providing universal or variable insurance or a policy providing benefits in the event of total and permanent disability or additional benefits for accidental death). No medical examination is required and the policy will become effective sixty-two (62) days after your Group Life Insurance terminates, provided the premium is paid to the Insurance Company not later than such date. The amount you may convert may, at your option, be equal to or less than the amount terminated under the Group Policy. However, if you cease to be a member of an eligible class of employees but continue to be employed by the Employer, the amount you convert will be reduced by the amount for which you are or become eligible under any other Group Policy within thirty-one (31) days after such termination.

You also have a conversion privilege with respect to any portion of your Life Insurance terminated due to retirement under the conditions set forth in the above paragraph.

If you die within sixty-two (62) days following termination of insurance as described in section 1, the Insurance Company will pay to your beneficiary the amount of Group Life Insurance you could have converted, even if you have not applied for conversion.

2. If your Group Life Insurance terminates because your Employer is no longer a Participating Employer under the Group Policy or the Group Policy is terminated or amended so as to terminate the insurance for the class of employees to which you belong, and you have been continuously insured under the Group Policy or any the Insurance Company policy it replaced, for at least five (5) years, you may also make application to convert your Group Life Insurance to an Individual Life Insurance policy upon the same conditions described in section 1 above. However, the maximum amount you may convert shall be the amount terminated under the Group Policy less any amount for which you may become eligible under any other Group Policy which replaces it within thirty-one (31) days after the Group Life Insurance terminates, but in no event shall the amount you may convert be more than $10,000.

If you die during the sixty-two (62) day period following the termination of your insurance as described in section 2, the Insurance Company will pay to your beneficiary the amount of Group Life Insurance you could have converted, even if you have not applied for conversion.
ACCIDENTAL DEATH AND
Dismemberment Insurance

Death and Dismemberment Benefits
Benefits are payable according to the following table if you suffer a loss as a result of accidental injury, while insured, whose cause is external, violent and purely accidental. The accident must happen while you are insured and the loss must occur within one hundred eighty (180) days after the date of the accident. All benefits other than benefits for loss of life are payable to you. Benefits for loss of life are payable to your beneficiary. You may change your beneficiary at any time.

The amount set forth in the Schedule of Benefits is payable for loss of:

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Benefit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>Full Amount</td>
</tr>
<tr>
<td>Both hands or both feet</td>
<td>Full Amount</td>
</tr>
<tr>
<td>Sight of both eyes</td>
<td>Full Amount</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>Full Amount</td>
</tr>
<tr>
<td>One hand and sight of one eye</td>
<td>Full Amount</td>
</tr>
<tr>
<td>One foot and sight of one eye</td>
<td>Full Amount</td>
</tr>
<tr>
<td>One hand</td>
<td>½ of Full Amount</td>
</tr>
<tr>
<td>One foot</td>
<td>½ of Full Amount</td>
</tr>
<tr>
<td>Sight of one eye</td>
<td>½ of Full Amount</td>
</tr>
<tr>
<td>Speech or hearing</td>
<td>½ of Full Amount</td>
</tr>
<tr>
<td>Thumb and index finger of same hand</td>
<td>¼ of Full Amount</td>
</tr>
</tbody>
</table>

NOTE: Loss of hand or foot means loss by severance at or above the wrist or ankle joint, and loss of sight, speech or hearing means total and irrecoverable loss of sight, speech or hearing; loss of thumb and index finger means loss by severance at the proximal phalangeal joint.

If you suffer more than one loss due to any one accident, payment will be made only for that loss for which the greatest benefit is payable. Payment will be made for the specific loss resulting from the accident without considering any previous loss.

Not Covered
Losses resulting from, or caused directly or indirectly, wholly or partly by:

1. Bodily or mental infirmity, bacterial infections (except infections caused by pyogenic organisms which shall occur with and through an accidental cut or wound) or disease or illness of any kind
2. Intentional self-destruction while sane or intentional self-inflicted injury
3. Participation in an insurrection or riot, war or an act of war, or service in any military or naval organization, unless such injuries are sustained while you are off-duty
4. Participation in, or in consequence of having participated in, the committing of a felony
5. Riding in or descending from any aircraft as a pilot or crew member

See also “General Information.”

980011-06 (PC-1001)
GENERAL INFORMATION

Beneficiary
You may change the beneficiary for your insurance for loss of life at any time. The change in beneficiary will take effect only upon its entry on the insurance records maintained in connection with the Group Policy.

Any part of your insurance for loss of life for which there is no designated beneficiary living at your death, will be payable in a single sum to the first surviving class of the following classes of successive preference beneficiaries: your (a) widow or widower; (b) surviving children; (c) surviving parents; (d) executors or administrators.

In the absence of the appointment of a legal guardian, any minor’s share may be paid at a rate not exceeding $50 a month to such adult or adults as have in the Insurance Company’s opinion assumed the custody and principal support of such minor.

Assignment of Life Insurance
No assignment by you of your Life Insurance under the Group Policy shall be valid except an assignment which recites that it is without consideration and that it is made to a named beneficiary. Such an assignment may be made without the consent of any beneficiary; however, such an assignment shall not be deemed to be effective unless in writing and accepted by the Insurance Company, and upon such acceptance it shall become effective as to the Insurance Company as of the date of assignment. Once such an assignment has been accepted and while it remains in force the assignee shall have the sole right to exercise any of the rights and privileges under the Group Policy thertofofore granted to you (including, but not limited to, the conversion privilege), and shall become entitled to receive all claim payments under the insurance assigned with respect to which no beneficiary is designated by the assignee, anything in the Group Policy to the contrary notwithstanding.

Acceptance of an assignment by the Insurance Company shall be without further liability as to any action or any payment or other settlement made by the Insurance Company before such acceptance.

No assignment by you of your Accidental Death and Dismemberment Insurance shall be valid.

Right of Recovery
If an overpayment is made due to any reason, including but not limited to clerical error or misstatement of age, the Insurance Company shall have the right to recover such overpayment from the insured person, or his/her beneficiary(ies).

Suicide
If Accidental Death and Dismemberment Insurance is provided in the Schedule of Benefits, suicide while insane is no defense to payment under the Accidental Death provisions of the Group Policy if you are a Missouri resident unless the Insurance Company can show that you intended suicide when you applied for the insurance, regardless of any language to the contrary in the Group Policy. Suicide while sane is a defense.

When Insurance Terminates
Your insurance terminates when you leave school employment, when you are no longer a member of an eligible class of employees, when your Employer is no longer a Participating Employer under the Group Policy, when the Group Policy terminated or upon cessation of contribution for the cost of your insurance, whichever happens first. A dependent’s insurance terminates when your insurance terminates or when that dependent is no longer an eligible dependent, whichever happens first.

980011-07 (PC-1001)
EMPLOYEE LIFE INSURANCE

Upon receipt of due proof of your death, the amount of Life Insurance for which you are insured under the Group Policy shall be payable to the beneficiary designated by you, as entered on the insurance records maintained in connection with the insurance under the policy. Any part of such insurance for which no beneficiary is designated or surviving at your death will be payable in accordance with the terms of the policy.

Protection after Termination

1. If your Group Life Insurance terminates because you leave school employment or because of your termination of membership in the class or classes of employees insured under the Group Policy, you may, within sixty-two (62) days after such termination of insurance, make application for any type of Individual Life Insurance policy then customarily issued by the Insurance Company (except a policy of term insurance, a policy providing universal or variable insurance or a policy providing benefits in the event of total and permanent disability or additional benefits for accidental death). No medical examination is required and the policy will become effective sixty-two (62) days after your Group Life Insurance terminates, provided the premium is paid to the Insurance Company not later than such date. The amount you may convert may, at your option, be equal to or less than the amount terminated, under the Group Policy. However, if you cease to be a member of an eligible class of employees but then continue to be employed by the Employer, the amount you may convert will be reduced by the amount for which you are or become eligible under any other Group Policy within thirty-one (31) days after such termination.

You also have a conversion privilege with respect to any portion of your Life Insurance terminated due to retirement under the conditions set forth in the above paragraph.

If you die within sixty-two (62) days following termination of insurance as described in this section 1, the Insurance Company will pay to your beneficiary the amount of Group Life Insurance you could have converted, even if you have not applied for conversion.

2. If your Group Life Insurance terminates because your Employer is no longer a Participating Employer under the Group Policy or the Group Policy is terminated or amended so as to terminate the insurance for the class of employees to which you belong, and you have been continuously insured under the Group Policy or any the Insurance Company policy it replaced, for at least five (5) years, you may also make application to convert your Group Life Insurance to an Individual Life Insurance policy upon the same conditions described in section 1 above. However, the maximum amount you may convert shall be the amount terminated under the Group Policy less any amount for which you may become eligible under any other Group Policy which replaces it within thirty-one (31) days after this Group Life Insurance terminates, but in no event shall the amount you may convert be more than $10,000.

If you die during the sixty-two (62) day period following the termination of your insurance as described in this section 2, the Insurance Company will pay to your beneficiary the amount of Group Life Insurance you could have converted, even if you have not applied for conversion.
GENERAL PROVISIONS APPLICABLE TO ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Upon receipt of due proof of claim, Accidental Death and Dismemberment benefits are payable to you, if living, otherwise to the beneficiary designated by you, as entered on the insurance records maintained in connection with the insurance under the policy. If no such designation is then effective, such benefits will be payable in accordance with the terms of the policy.

Notice of Claim
Written notice of the event upon which claim may be based must be given to the Insurance Company within twenty (20) days after the date of the loss for which claim is made. Failure to give notice within the time required by the policy shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to give such notice within the required time and that notice was given as soon as was reasonably possible.

Upon receipt of such notice, you will be furnished forms for filing proof of claim. If such forms are not furnished within fifteen (15) days after the receipt of notice the claimant shall be deemed to have complied with the requirements of the policy as to proof of claim upon submitting within ninety (90) days after the date of the loss for which claim is made, written proof covering the occurrence, character and extent of the loss for which claim is made.

Proof of Claim
Written proof of claim must be furnished to the Insurance Company, on the Insurance Company’s forms within ninety (90) days after the date of the loss for which claim is made. Failure to furnish written proof of loss within the time required by the policy shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof within the required time and that proof was furnished as soon as was reasonably possible.

Examinations
The Insurance Company shall have the right and opportunity through its medical representative to examine any person when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

Legal Proceedings
No action at law or in equity shall be brought to recover under the policy prior to the expiration of sixty (60) days after proof of claim has been furnished in accordance with the requirements of the policy, nor shall any such action be brought at all unless commenced within ten (10) years from the expiration of the time within which proof of claim is required by the provisions thereof.
CLAIM PAYMENT AMENDATORY RIDER

Subscriber: Michigan Education Special Services Associates (MESSA)

Policy No.: FLI-980011

Effective Date: March 26, 2014

This Amendatory Rider is attached to and made a part of the Policy/Certificate specified above.

The Policy/Certificate is amended as follows under:

Claim Provisions

Manner of Payment of Claims

The Subscriber authorizes that any benefit payment due as a lump sum of $5,000.00 or more shall be credited to a draft account with the Insurance Company, in the name of the beneficiary. The beneficiary may withdraw the entire proceeds at any time by issuing one or more drafts, or may withdraw lesser amounts, subject to a minimum account balance set by the Insurance Company from time to time. Interest shall be credited to such account at rates as determined from time to time by the Insurance Company.

Administrative Provisions

Draft Accounts

The Insurance Company shall be entitled to retain, as part of its compensation, any earnings on draft accounts created in connection with benefit claims, in excess of interest credited under the terms of the policy.

Life Insurance Company of North America

Matthew G. Manders, President

RA-TL-1000.00
LONG TERM DISABILITY INSURANCE
CERTIFICATE BOOKLET

GROUP INSURANCE FOR
FERNDALE SCHOOL DISTRICT

SCHOOL NUMBER 069

OFFICE PERSONNEL
The benefits for which you are insured are set forth in the pages of this booklet. Consult these pages for a further description of the terms and conditions of this coverage. Application must be made and signed by the individual before any coverage can become effective. If your plan requires contributions from you, the coverage will not become effective unless you are making the required contributions.
LIFE INSURANCE COMPANY OF NORTH AMERICA
derby certifies that, members of

MICHIGAN EDUCATION
SPECIAL SERVICES ASSOCIATION
(Herein called the Policyholder)

who are insured under Group Policy Number LK-980031 issued by Life Insurance Company of North America to the Policyholder are, subject to the terms and conditions of said Policy, insured for the benefits described in the Benefits provision.

BENEFITS

Benefits for which you are insured are set forth in the pages of this booklet. Consult these pages for a further description of the terms and conditions of these coverages. If there is any coverage for which you are eligible which does not become effective unless you make the required election and contributions therefor, such coverage will not become effective unless you so elect and are making such contributions.

This Certificate, which is furnished in accordance with, and subject to, the terms of the Group Policy, replaces any and all Certificates previously issued to you by the Insurance Company under the Group Policy specified above covering the insurance described herein. This is not the contract of insurance. Each policy and the application of the Policyholder for it constitute the entire contract. This Certificate is merely evidence of insurance provided under the Group Policy. The insurance is effective only after the person concerned is eligible for insurance and becomes and remains insured in accordance with the terms, provisions and conditions of the Group Policy.

Matthew G. Manders, President
# Table of Contents

CUSTOMER PRIVACY NOTICE ........................................................................................................... 2
  What Personal Information We Collect ......................................................................................... 2
  When We Collect It ......................................................................................................................... 2
  Other Sources We Use .................................................................................................................... 2
  What Personal Information We Use and Share ............................................................................. 3
  Protection of Your Personal Information ...................................................................................... 4
  Seeing and Correcting Your Personal Information ....................................................................... 4
  Additional Rights Under Other Privacy Laws ............................................................................... 4
  Who We Are .................................................................................................................................. 5
  Questions or Concerns about this Privacy Notice ......................................................................... 5

SCHEDULE OF BENEFITS .................................................................................................................. 6

WHEN YOUR INSURANCE BEGINS .................................................................................................. 8
  Becoming Eligible ............................................................................................................................ 8
  Becoming Insured ............................................................................................................................ 8

LONG TERM DISABILITY BENEFITS .............................................................................................. 9
  Loss of Time Benefits ..................................................................................................................... 9
  How Much ...................................................................................................................................... 9
  Income from other Sources ............................................................................................................ 9
  Minimum Monthly Benefit ............................................................................................................. 10
  Single Sum Payments Under Other Plans ................................................................................... 11
  Definition of Total Disability ........................................................................................................ 11
  Definition of Qualifying Period ....................................................................................................... 11
  When do Benefits Begin and End ................................................................................................. 11
  Successive Periods of Disability .................................................................................................... 11

WHEN INSURANCE TERMINATES .................................................................................................... 12

N OT COVERED .................................................................................................................................. 12

WAIVER OF HEALTH PLAN CONTRIBUTIONS DURING DISABILITY ............................................ 13

MINIMUM MONTHLY BENEFIT ...................................................................................................... 13

COST OF LIVING ADJUSTMENT ..................................................................................................... 14

SURVIVOR INCOME BENEFIT ......................................................................................................... 15

REHABILITATION BENEFITS ......................................................................................................... 16
  Rehabilitation Services ................................................................................................................... 16
  Benefit During Rehabilitative Employment .................................................................................... 16

LONG TERM DISABILITY INSURANCE ........................................................................................... 17
  Time Limit on Certain Defenses .................................................................................................... 17
  Notice of Claim ............................................................................................................................... 17
  Claim Forms .................................................................................................................................. 17
  Proof of Loss .................................................................................................................................. 17
  Time of Payment of Claims .......................................................................................................... 17
  Physical Examination .................................................................................................................... 17
  Legal Actions ................................................................................................................................. 18

GENERAL INFORMATION ................................................................................................................ 19
  How to File a Claim ......................................................................................................................... 19
  How to Appeal a Claim Denial ....................................................................................................... 19
  Right of Recovery .......................................................................................................................... 19
Customer Privacy Notice

Privacy Notice of Cigna Corporation and its Affiliates (referred to in this notice as “we, our and us”). This privacy notice applies to our United States Operations.

We value your trust. We are committed to acting responsibly when we collect, use and protect your personal information.

Please read this privacy notice carefully. It explains the rules we at Cigna follow when we collect personal information. This notice applies to all personal information we collect about you.

Financial companies, including insurers, choose how they share your personal information. Federal and state laws say that we must tell you how we collect, share and protect your personal information.

What Personal Information We Collect

The types of information we collect, use and share depend on the product or service you have from us. It may include your:

- Name
- Telephone number
- Occupation
- Social Security number
- Address
- Date of birth
- Financial and health history
- Insurance claims information

When We Collect It

We collect your personal information when you:

- Apply for insurance
- File a claim
- Obtain services from us
- Pay premiums
- Give us your contact information

Other Sources We Use

We also collect personal information about you from others such as:

- Affiliates (Affiliates are companies related by common ownership or control)
- Other insurers
- Service providers
- Health Care Professionals
- Insurance support organizations

We may also get information from consumer reporting agencies. This might include the following records:

- Driving record
- Credit report
- Claims history with other insurers

Consumer reporting agencies may keep your information. They may disclose it to others.

Cat# 868710 © 2013 Cigna.
## What Personal Information We Use and Share

### For everyday business purposes

We may share all of the personal information about you that we collect with Affiliates and nonaffiliated companies (companies that are not under common ownership with us, such as our service providers), for any purpose the law allows. For example, we may use your personal information and share it with others to:

- Help us run our business
- Process your transactions
- Maintain your account(s)
- Administer your benefit plan
- Respond to court orders and legal or regulatory investigations or exams
- Report to credit bureaus
- Support or improve our programs or services, including our care management and wellness programs
- Offer you our other products and services
- Do research for us
- Audit our business
- Help us prevent fraud, money laundering, terrorism and other crimes by verifying what we know about you
- Sell all or any part of our business or merge with another company

We may also share your personal information with:

- Medical health care professionals
- Insurers, including reinsurers
- Successor insurers or claim administrators who administer your benefit plan
- Companies that help us recover overpayments, pay claims or do coverage reviews

### For our marketing purposes

We may share information with our agents and service providers to offer our products and services to you.

### For joint marketing with other financial companies

We may share your personal information with other financial companies for the purpose of joint marketing. Joint marketing is when there is a formal agreement between nonaffiliated financial companies that jointly endorse, sponsor or market financial products or services to you.

We may also share personal information about former customers in the way described above. Federal laws don’t allow you to limit the sharing of personal information as described above.

Cat# 868710 © 2013 Cigna.
### Protection of Your Personal Information

**How do we protect your personal information?**

To protect personal information from unauthorized access and use, we:

- Use reasonable security measures, including secured files, user authentication, encryption, firewall technology, and detection software
- Review the data security practices of companies we share your personal information with
- Grant access to personal information to people who must use it to do their jobs

### Seeing and Correcting Your Personal Information

**How can you see and correct your personal information?**

Generally, you have the right to review the personal information we collect to provide you with insurance products and services if you:

- Ask us in writing
- Send the letter to the address below

When you write to us, please include your full name, address, telephone number and policy number in your letter.

If the information you ask for includes health information, we may provide the information to you through your health care provider. Due to its legal sensitivity, we won’t send you anything that we’ve collected in connection with a claim or legal proceeding.

If you believe the personal information we have is incorrect, please write to us and explain why you believe it is incorrect. If we agree with you, we will correct our records. If we disagree with you, you may send us a statement and we will include it when we give your personal information to anyone outside of Cigna.

### Additional Rights Under Other Privacy Laws

You may have additional rights under state or other applicable laws.
Who We Are

This privacy notice is provided by Cigna Corporation and its Affiliates:

- American Retirement Life Insurance Company
- Central Reserve Life Insurance Company
- Cigna Behavioral Health, Inc.
- Cigna Benefits Financing, Inc.
- Cigna Dental Health of California, Inc.
- Cigna Dental Health of Colorado, Inc.
- Cigna Dental Health of Delaware, Inc.
- Cigna Dental Health of Florida, Inc.
- Cigna Dental Health of Kansas, Inc.
- Cigna Dental Health of Kentucky, Inc.
- Cigna Dental Health of Maryland, Inc.
- Cigna Dental Health of Missouri, Inc.
- Cigna Dental Health of New Jersey, Inc.
- Cigna Dental Health of North Carolina, Inc.
- Cigna Dental Health of Ohio, Inc.
- Cigna Dental Health of Pennsylvania, Inc.
- Cigna Dental Health of Texas, Inc.
- Cigna Dental Health of Virginia, Inc.
- Cigna Dental Health Plan of Arizona, Inc.
- Cigna Dental Health, Inc.
- Cigna Health and Life Insurance Company
- Cigna Health Care of North Carolina, Inc.
- Cigna Health Corporation
- Cigna HealthCare Connecticut, Inc.
- Cigna HealthCare of Arizona, Inc.
- Cigna HealthCare of California, Inc.
- Cigna HealthCare of Colorado, Inc.
- Cigna HealthCare of Florida, Inc.
- Cigna HealthCare of Georgia, Inc.
- Cigna HealthCare of Illinois, Inc.
- Cigna HealthCare of Indiana, Inc.
- Cigna HealthCare of New Jersey, Inc.
- Cigna HealthCare of South Carolina, Inc.
- Cigna HealthCare of St. Louis, Inc.
- Cigna HealthCare of Tennessee, Inc.
- Cigna HealthCare of Texas, Inc.
- Cigna Life Insurance Company of New York
- Connecticut General Life Insurance Company
- Life Insurance Company of North America
- Loyal American Life Insurance Company
- Provident American Life & Health Insurance Company
- United Benefits Life Insurance Company

Questions or Concerns about this Privacy Notice

Write to us at: Cigna Corporation
Enterprise Privacy Office
P.O. Box 188014 Chattanooga,
TN 37422

Securities are offered through Cigna Benefits Financing, Inc., Member FINRA, 900 Cottage Grove Rd., A4COL, Bloomfield, CT 06002.


Cat# 868710 © 2013 Cigna.

Rev. November 7, 2013

Cat# 868710 © 2013 Cigna.
SCHEDULE OF BENEFITS
To be attached to and made part of your Booklet

For Members of
FERNDALE SCHOOL DISTRICT

PLAN EFFECTIVE DATE: May 1, 2018

MEMBERS INCLUDED: OFFICE PERSONNEL

DATE OF ELIGIBILITY: You will be eligible on the Plan Effective Date, the date of your employment, or the day following completion of the eligibility waiting period as determined by your Employer, whichever is later.

LONG TERM DISABILITY

Maximum Monthly Benefit: 66 2/3% of monthly earnings subject to a maximum benefit of $3,000.

Qualifying Period - Benefits begin:

1. Upon the exhaustion of accumulated sick days, or upon expiration of 180 calendar days of disability accumulated in any twelve (12) consecutive months, whichever is later.

   Or

2. Upon expiration of three (3) consecutive days of disability occurring during a school year in which the Qualifying Period was previously satisfied.

NOTE: The last three (3) sick days or days of disability under 1. above must be consecutive and due to the same or related cause.

Regular Occupation Total Disability Period: 2 years

Maximum Period of Payment:

1. For disability commencing prior to age 60 - up to age 65

2. For disability commencing at or after age 60 and prior to age 66 - up to 5 years

3. For disability commencing at or after age 66 - up to the following periods:

<table>
<thead>
<tr>
<th>Disabled at Age</th>
<th>Duration of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>66</td>
<td>4 years</td>
</tr>
<tr>
<td>67</td>
<td>3 years</td>
</tr>
<tr>
<td>68</td>
<td>2 years</td>
</tr>
<tr>
<td>69 or later</td>
<td>1 year</td>
</tr>
</tbody>
</table>
Social Security Benefits Integrated with Monthly Benefits: Primary and Family Benefits

Minimum Monthly Benefit: Five percent (5%) of your Maximum Monthly Benefit before reduction of Income From Other Sources or $50, whichever is greater (for disabilities commencing on or after July 1, 1986).

Freeze on Offsets: Future monthly LTD benefits will not be reduced because of automatic, statutory or general cost of living increases in income amounts used as monthly benefit offsets. If any such income amounts are initially estimated, these amounts will be adjusted to reflect the final determination.

Cost of Living Adjustment: Included

Limited Benefits for Disability due to Mental Disease or Illness: Same as any other illness

Limited Benefits for Disability due to Alcoholism or Drug Abuse: Same as any other illness

Benefits for Disabilities due to Pregnancy: Included

Rehabilitation Benefits: Included

Waiver of MESSA Health Care Plan Contributions During Total Disability: up to 24 months for any one period of disability commencing on or after July 1, 1986.

Monthly earnings shall mean one-twelfth (1/12) of your annual rate of compensation not including bonuses, commissions or any other special compensation.
WHEN YOUR INSURANCE BEGINS

Becoming Eligible
You will be eligible for insurance as determined in accordance with the paragraph entitled Date of Eligibility in the Schedule of Benefits.

Becoming Insured
If you are not required to contribute toward the cost of your insurance, you will become insured on the day you become eligible.

If you are required to pay any portion of the cost of your insurance, you will become insured on the latest of:

1. The day you become eligible, if you enroll for your insurance on or before the day you become eligible
   Or

2. The day you enroll for your insurance, if you enroll on or before the thirty-first (31st) day following the day you become eligible
   Or

3. The day your evidence of insurability (at your expense) is approved by the Insurance Company, if you enroll for your insurance more than thirty-one (31) days following the day you become eligible

You must be actively at work on the day that your insurance is to become effective. If you are absent from work because of bodily injury or sickness on that day, you will become insured on the day you return to active work. To be considered actively at work for insurance purposes, you must be physically able to perform your normal duties for a regularly scheduled workday at the time you report to work.
LONG TERM DISABILITY BENEFITS

Loss of Time Benefits
If you become totally disabled by an accidental injury or sickness while insured and remain continuously so disabled beyond the Qualifying Period shown in the Schedule of Benefits, monthly benefits will be paid to you. However, if a total disability commences while you are on an approved leave of absence without pay, the Qualifying Period shall not begin to accumulate until the date you are scheduled to return to active school employment.

How Much
The Monthly Benefit while you are totally disabled shall be the Maximum Monthly Benefit shown in the Schedule of Benefits based on your monthly earnings at the time disability commences, less any benefits you are eligible to receive for that month as income from other sources as described below.

Income from other Sources
Your Maximum Monthly Benefit will be reduced by the amount of the following other income benefits:

1. Any earnings, including salary, wages, commissions or similar pay, you receive or are entitled to receive from work including earnings from your employer, any other employer or self-employment,

2. The amount of any disability or retirement benefits you receive from your employer’s retirement or pension plan, including the Michigan Public School Employees’ Retirement Fund,

3. Any amount you receive or are eligible to receive from Social Security or Railroad Retirement (integrated as shown in the Schedule of Benefits) by reason of your disability or retirement,

4. Any amount you receive or are eligible to receive as a periodic benefit for disability under
   i. Any employer’s, labor-management trustee, or union employee benefit plan
   ii. Any governmental (not military) agency or program or coverage required or provided by law; i.e., Workers’ Compensation

NOTE: Until you submit proof satisfactory to the Insurance Company that you are not entitled to the disability benefits provided above, the Insurance Company will assume that you are entitled to the maximum amount of such periodic benefit, including dependent benefits, applicable to the class of persons of which you are a member.
Minimum Monthly Benefit
Your Monthly Benefit will not, in any case, be less than five percent (5%) of your Maximum Monthly Benefit before reduction of Income From Other Sources or $50, whichever is greater.

Example:  
$2,000.00  Monthly Earnings  
\times 66 \frac{2}{3}\%  Monthly Benefit Percentage for this example  
1,334.00  Maximum Monthly Benefit  
-1,300.00  Income From Other Sources  
$34.00  Monthly Benefit after total offsets  

$66.70  The amount equal to 5% of your Maximum Monthly Benefit

The Minimum Monthly Benefit Provision will increase the $34.00 to the greater of $50.00 or 5% of the Maximum Monthly Benefit or, in this example, $66.70.
Single Sum Payments Under Other Plans
If a single sum payment is made as a commutation of, or substitute for, any periodic benefits or payments referred to under “Income From Other Sources,” such payment shall be deemed to have been made in the amounts and for the period which would have been applicable in the absence of such single sum payment.

Definition of Total Disability
You will be considered “totally disabled” if you are wholly and continuously unable to perform any and every duty pertaining to your regular occupation during the Qualifying Period and the Regular Occupation Total Disability Period shown in the Schedule of Benefits. After benefits have been paid for the Regular Occupation Total Disability Period of any continuous disability you will be considered “totally disabled” for the balance of the period of disability if you are unable to engage in any occupation or perform work for compensation or profit for which you are, or may become, reasonably fitted by training, education or experience.

You are not totally disabled during any period in which you are not under the regular care and attendance of a physician.

Definition of Qualifying Period
The term “Qualifying Period” means the period of days of total disability, shown in the Schedule of Benefits, for which no Monthly Benefit is payable.

When do Benefits Begin and End
Monthly Benefits will accrue from the first day after the Qualifying Period and will be payable while you continue to be so totally disabled, if due proof of the disability is given to the Insurance Company. However, benefits will not be payable beyond the Maximum Period of Payment shown in the Schedule of Benefits.

Successive Periods of Disability
Successive periods of disability beginning while you are insured will be treated as one period of disability unless they are:

1. Due to different and unrelated causes and separated by return to active school employment for at least one day
   Or
2. Due to the same or related causes and separated by more than six (6) months of continuous active school employment
WHEN INSURANCE TERMINATES

Your insurance terminates on the earliest of the following dates:

1. The date you leave school employment
   Or
2. The date you are no longer a member of a class eligible for this insurance
   Or
3. The date the Group Policy terminates

In addition, your insurance terminates on the date you cease performing all the usual duties of your job, except that your coverage may be extended while:

1. You are unable to work because you are sick or injured
   Or
2. You are on a leave of absence with pay, for a period not to exceed one year
   Or
3. You are on a leave of absence without pay, for a period not to exceed one year, provided there is a signed contract or other written agreement stating the date you will be returning to active work.

In no event may any insurance provided on a contributory basis be continued beyond the end of the period for which the Member has made the premium contribution required.

Any claim established prior to the date your insurance terminates will not be affected by such termination.

NOT COVERED

No benefits are payable for disability due to:

1. Self-inflicted injuries if intentional or while insane
2. War
3. Participation in, or in consequence of having participated in, the committing of a felony
4. Cosmetic surgery unless (a) occasioned by accidental bodily injury sustained while insured or active illness contracted while insured, and (b) you have been continuously insured under this Group Long Term Disability program since such injury was sustained or such illness was contracted

980031-05 (PC-1002)
WAIVER OF HEALTH PLAN CONTRIBUTIONS
DURING DISABILITY

The monthly contributions for your MESSA health plan will be waived during any one period of disability under the following conditions:

1. The Waiver will begin when you become entitled to Monthly Benefits and will continue while you are totally disabled but not to exceed twenty-four (24) months

2. The Waiver will apply to health plan contributions which become due while you are entitled to Monthly Benefits but not beyond the date that twenty-four (24) monthly contributions have been waived

3. The Waiver will not apply during any part of this twenty-four (24) month period in which:
   
i. Your Employer, because of your disability, is required by contract or other agreement to make monthly contributions for your MESSA health plan

   Or

   ii. You are eligible for benefits under the Michigan Public School Employees’ Retirement System

4. Health plan does not include the Hospital Confinement Indemnity plan

NOTE: Until you submit proof satisfactory to the Insurance Company that you are not entitled to the disability benefits provided above, the Insurance Company will assume that you are entitled to the maximum amount of such periodic benefit, including dependent benefits, applicable to the class of persons of which you are a member.

MINIMUM MONTHLY BENEFIT

Your Monthly Benefit will not, in any case, be less than the Minimum Monthly Benefit as shown in the Schedule of Benefits.
COST OF LIVING ADJUSTMENT

The plan provides a cost of living adjustment of Long Term Disability payments on each anniversary of the commencement of benefit payments. This adjustment, based on changes in the Consumer Price Index as of each January 1 or other reliable index determined by the Insurance Company to be more appropriate, was built into the plan in order to recognize changes in the cost of living. No one cost of living adjustment will increase the amount of your Monthly Benefit by more than three percent (3%) of the amount payable immediately prior to each anniversary of the commencement of benefit payments.
SURVIVOR INCOME BENEFIT

In the event of your death while you are receiving Long Term Disability Benefits and prior to the expiration of the Maximum Period of Payment, as shown in the Schedule of Benefits, the Insurance Company will pay to your surviving spouse a lump sum benefit equal to six (6) times the last Monthly Benefit you were entitled to receive. In the event there is no surviving spouse at your death, the lump sum payment will be made to your surviving eligible children, in equal shares. Eligible children shall mean your natural children, stepchildren, adopted children and foster children who are under age twenty-one (21). If there is neither a surviving spouse nor any surviving eligible children at the time of your death, no lump sum survivor benefit will be paid.
REHABILITATION BENEFITS

Rehabilitation Services
If you become disabled as a result of injury or sickness, the Insurance Company may, at its sole discretion, provide rehabilitation services. The decision to provide these services will be based on an objective review of the medical condition causing your disability, your potential to return to work and the types of services needed to improve your quality of life as a disabled person. The Insurance Company will pay benefits up to the reasonable and customary charges for rehabilitation services furnished under this provision.

Benefit During Rehabilitative Employment
If you have received Long Term Disability Benefits for any one period of disability and you accept Rehabilitative Employment, you will receive a Monthly Benefit for an additional twenty-four (24) months during such Rehabilitative Employment. Your Monthly Benefit will be the Monthly Benefit otherwise payable less fifty percent (50%) of the amount of your earnings from Rehabilitative Employment.

“Rehabilitative Employment” means any occupation or employment for compensation or profit for which you are reasonably fitted by training, education or experience provided such Rehabilitative Employment is performed during a period in which you are unable to perform any and every duty pertaining to your regular occupation.
LONG TERM DISABILITY INSURANCE

Long Term Disability insurance benefits are payable pursuant to the following provisions:

Time Limit on Certain Defenses
No statement relating to insurability made by any Member eligible for coverage under the policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of three (3) years during the lifetime of the person with respect to whom any such statement was made.

NOTE: For the purpose of the following provisions, information submitted to MESSA shall be considered to have been furnished to the Insurance Company as herein specified.

Notice of Claim
Written notice of claim must be given to the Insurance Company no later than thirty (30) days prior to the expiration of the Qualifying Period, or as soon thereafter as is reasonably possible. Notice given by or on behalf of you or the beneficiary to the Insurance Company at its Home Office or to any authorized agent of the insurance Company, with information sufficient to identify you, shall be deemed notice to the Insurance Company.

Claim Forms
The Insurance Company, upon receipt of a written notice of claim, will furnish to the Member such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the Member shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss
Written proof of loss must be furnished to the Insurance Company within ninety days after the termination of the first due monthly period of benefits following the expiration of the Qualifying Period. Subsequent written proof of the continuance of such disability must be furnished to The Insurance Company at such intervals as it may reasonably require. The Insurance Company shall require as part of proof of loss satisfactory evidence (1) of the amount of all benefits and payments referred to in the insurance plan, and (2) that you have made application for such benefits and payments and have furnished all required proofs therefore.

Time of Payment of Claims
Subject to the due written proof of loss, all accrued benefits for loss for which the policy provides periodic payment shall be paid to the Member monthly during the period for which benefits are payable thereunder, and any balance remaining unpaid at the termination of the period of liability will be paid immediately upon receipt of due written proof.

Physical Examination
The Insurance Company (at its own expense) shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the pendency of a claim under the policy.
Legal Actions
No action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.
GENERAL INFORMATION

How to File a Claim
You should notify the MESSA Benefits office 30 days prior to the end of your Qualifying Period that you wish to file a Long Term Disability claim. MESSA will immediately send you the necessary claim form and detailed claim filing instructions.

How to Appeal a Claim Denial
If you do not agree with a claim denial, you may request that a review be made of your claim. You should submit a written request for a review of your claim within 60 days after receiving notice of denial. Your request should be addressed to the attention of the MESSA Benefits office.

You may submit additional information with your request for review. You may request and receive copies of pertinent documents, although in some cases authorization may be needed for the release of confidential information, such as medical records. You should submit the facts and any supporting comments in writing.

A decision will be made by the Insurance Company within 60 days following MESSA’s receipt of request for review or the date all information required of you is furnished, whichever date is later. Notification of the decision on review will be written in a manner calculated to be understood by you and will specify the reasons for the decision.

Right of Recovery
If an overpayment is made due to any reason, including but not limited to a payment under any Worker’s Disability or Occupational Disease Act or Law, clerical error or misstatement of age, the Insurance Company shall have the right to recover such overpayment from the insured person, or to deduct such amount of overpayment from future benefits.

If you incur expenses on account of bodily injury or sickness, caused by negligence or wrong of a third party and benefits are payable, under the Group Policy, you will receive the benefits, provided that, if there is recovery by you or a personal representative from the third party, or his or her personal representative whether by judgment settlement or otherwise, on account of such bodily injury or sickness, you shall reimburse the Insurance Company to the extent of the total amount of such benefits paid under the Group Policy, but not to an amount in excess of the proceeds of any such recovery after the deduction of reasonable and necessary expenditures, including attorney’s fees, incurred in effecting such recovery.