

Online Benefits Website User Guide for Employees

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OVERVIEW

MESSA has partnered with a leading industry enrollment vendor to provide an Online Enrollment Website for your school business offices and you. MESSA's online enrollment website is user-friendly and is designed to assist you in updating your benefits, family statuses and job changes.

What this means for you:

- Information. You can see your benefit and enrollment options, review and update personal and family information.
- Convenience. The site is accessible 24/7 wherever there is an internet connection.

If you have any questions, please contact the MESSA Member Service Center at 800.336.0013.

Employee Responsibilities

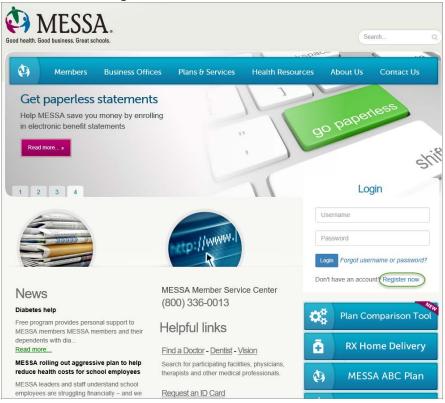
- Once your information has been added to MESSA's online enrollment website by your employer, you will receive an email notifying you that you can log into the online benefits website using the <u>www.messa.org</u> employee portal. (For Newly Hired Employees)
- You will need to verify your demographic (personal) information, ad or update your dependent information and elect your benefits.
- All benefit elections will be sent to your employer for approval.

ACCESSING MESSA'S ONLINE BENEFITS WEBSITE

The online benefits website is available 24 hours a day, seven days a week for you to enter and review your contact information, benefit enrollment information, eligible dependents, beneficiaries and more.

First Time Logging Into MESSA.org

- Open the MESSA website by going to <u>www.messa.org.</u>
- Click on "Register Now."



- Enter the following information to create a messa.org account:
 - o Last four digits of your Social Security Number
 - o Date of birth
 - o Employer
 - Home zip code
- Click "Next."

My MESSA		
Registration		
Step 1: User information		
Enrollee ID/SSN (last 4 digits)	Employer A01-Unknown Or Unassigned	~
Date of birth	Home zip code	
		Next

• Select your security questions and enter your answers.

Click "Next."			
My MESSA.			
Registration			
🕑 User Validated			Why register?
Step 2: Security Questions			You can:
Question 1		Answer 1	View deductibles, claims and explanation of benefits statements
Select a question	~		Find doctors, hospitals and other providers
Question 2		Answer 2	Show your virtual ID card
Select a question	~		Securely contact MESSA's award- winning customer support
Question 3		Answer 3	
Select a question	~		Access your account anytime and anywhere
Question 4		Answer 4	
Select a question	~		
Question 5		Answer 5	

- A confirmation code will be sent to the email address you used when creating your account.
- Enter the Confirmation code.
- Click "Confirm."

My MESSA.		
Welcome to MESSA!		
Please enter the confirmation code sent to	for registration confirmation in the box below and select "Confirm".	
To resend the code select "Resend".		
Confirmation code		
Resend		

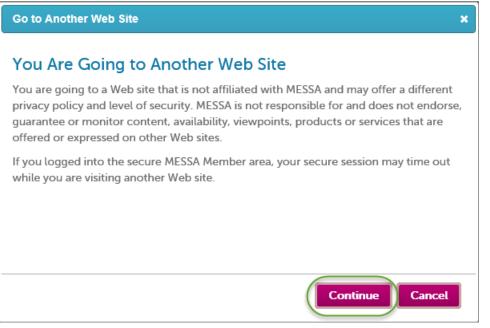
- **1.** Create a username.
- 2. Create a password.
- **3.** Confirm your password.
- **4.** Click the "I'm not a robot" box.
- 5. Enter your email address.
- **6.** Confirm your email address
- 7. Check the "I agree to the MESSA Web Terms of Use" box and check the "Yes, send my EOB statements electronically" box if you'd like your Explanation of Benefits emailed to you.
- Click "Register now".

6 800.336.0013	Username	Password	Login Search Q
My MESSA			
Registration		W	ny register?
Security Questions Accepted		You	i can:
Step 3: Username and Password		exp	fiew deductibles, claims and lanation of benefits statements Find doctors, hospitals and other
Suggestion: Ejohansson			viders Show your virtual ID card
Your password must be at least eight characters in length and M - One uppercase letter - One lowercase letter - One number - One special character (e.g., =!@#\$%^&*()_+-) 2 Password	UST contain AT LEAST	win @ A	ecurely contact MESSA's award- ning customer support Access your account anytime and where
I'm not a robot			
5 Email 6 Confir	m email		
<i>Go paperless!</i> You can receive your Explanation of Benefits statements electronically a You can change back to paper statements any time by changing your ac	Charles of the second	of by postal mail.	
I agree to the MESSA Web Terms of Use	(Register now	

- Once logged in to your account, click on the "Online benefits website" link in the box on the left side of the screen. (If you do not see this link, logout and log back in and it will appear.)
- The Employee User Guide link is located under the "Online benefits website" link. This user guide will give you step by step instructions.

[27Update	Current ye					
	Family dec	ar © Previou ductible prog			n-network ,000 <i>Tc</i>	◎ Out-of-network
ilee ID loyer(s)				\$3	21.48 N	let
ctive date(s) 5/1/2017 dditional family members	\$0	5321.4	8 \$4,000	\$3	,678.52	Remaining
Online benefits website	Claim totals	Amount billed \$630.11	Provider savings \$339.48	MESSA payment \$0.00	Deductible \$290.63	Copayment/ coinsurance \$0.00
Employee user guide			\$339.48 \$44.06	\$0.00	\$290.63 \$30.85	\$0.00
	Total Pharmacy Totals	\$74.91 \$705.02	\$383.54	\$0.00	\$321.48	\$0.00

- You will receive a pop-up letting you know that you are going to another web site.
- Click "Continue."
- This will take you directly to MESSA's Online Benefits Website.



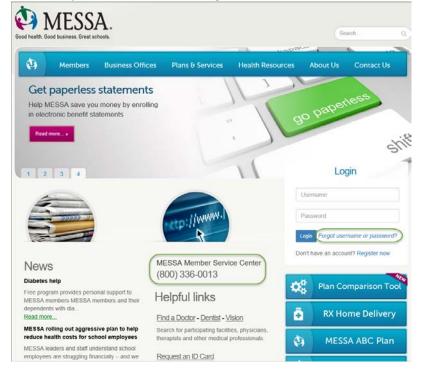
• Once you have completed creating your MESSA.org account and are on the online benefits website, see the "New Hire" section in this guide for instructions on how to enroll in benefits.

Active MESSA.org Account

• Go to <u>www.messa.org</u> and log in using your current username and password.



- If you have forgotten your password or are having trouble logging in, please click on "Forgot Username or Password?"
- If you are still unable to log in, contact MESSA's Member Service Center at 800.336.0013.



• Once you are logged into MESSA's secure member portal, click on the "**Online benefits website**" link in the box on the left side of the screen.

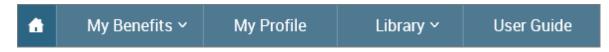
Plan 2	Deductible Ou	it-of-pocket				
[2ℓUpdate]	PTT 32517220	ear 🛛 Previou		* I	n-network	Out-of-network
	Family dec	ductible prog	ress	\$4	,000 To	otal
lee ID				\$3	21.48	let
oyer(s)		1004 4	•			ilee in the second s
tive date(s) 5/1/2017		\$321.4		¢7	679 53	Domaining
ditional family members	\$0	mer	\$4,000	-¢-3	,070.32	Remaining
hEquity View your account >	SUMMARY View all deductible cla			overage		mber responsibility
\$	View all deductible cla	Amount billed		overage MESSA payment	Mer	mber responsibility Copayment/ coinsurance
ShEquity View your account >	View all deductible cla Claim totals Total Medical	Amount billed \$630.11	Provider savings \$339.48	MESSA payment \$0.00	Deductible \$290.63	Copayment/ colnsurance \$0.00
View your account > Online benefits website Employee user guide	View all deductible cla	Amount billed	Provider savings	MESSA payment	Deductible	Copayment/ coinsurance
S thEquity View your account > Online benefits website	View all deductible cla Claim totals Total Medical Total Pharmacy	Amount billed \$630.11 \$74.91	Provider savings \$339.48 \$44.06	MESSA payment \$0.00 \$0.00	Deductible \$290.63 \$30.85	Copayment/ coinsurance \$0.00 \$0.00
S hEquity View your account > Online benefits website Employee user guide	View all deductible cla Claim totals Total Medical Total Pharmacy	Amount billed \$630.11 \$74.91	Provider savings \$339.48 \$44.06	MESSA payment \$0.00 \$0.00	Deductible \$290.63 \$30.85	Copayment/ coinsurance \$0.00 \$0.00
S hEquity View your account > Online benefits website Finployee user guide View EOB statements	View all deductible cla Claim totals Total Medical Total Pharmacy	Amount billed \$630.11 \$74.91	Provider savings \$339.48 \$44.06	MESSA payment \$0.00 \$0.00	Deductible \$290.63 \$30.85	Copayment/ coinsurance \$0.00 \$0.00
Subcount View your account > Conline benefits website Conline benefits Conline	View all deductible cla Claim totals Total Medical Total Pharmacy	Amount billed \$630.11 \$74.91	Provider savings \$339.48 \$44.06	MESSA payment \$0.00 \$0.00	Deductible \$290.63 \$30.85	Copayment/ coinsurance \$0.00 \$0.00

- You will receive a pop-up letting you know that you are going to another web site.
- Click "Continue."
- This will take you directly to MESSA's Online Benefits Website.

Go to Another Web Site X
You Are Going to Another Web Site
You are going to a Web site that is not affiliated with MESSA and may offer a different privacy policy and level of security. MESSA is not responsible for and does not endorse, guarantee or monitor content, availability, viewpoints, products or services that are offered or expressed on other Web sites.
If you logged into the secure MESSA Member area, your secure session may time out while you are visiting another Web site.
Continue Cancel

HOME PAGE

This website has been created to provide you with information about your benefits. You will have the ability to enroll online and update your personal and dependent information. The tabs at the top of the page have the following information:



My Benefits

- Current Benefits shows the details of all current benefits.
- Life Events used to create an enrollment window if you have a qualifying event (within MESSA's eligibility guidelines of 30 days) that allows benefit changes.

My Benefits 🗸
Current Benefits
Life Events

My Profile

- Personal Information View/edit address information
- Family Information View/edit dependent information
- Beneficiaries View/edit beneficiary information
- Security Question Change security questions
- Life Event Create a "Life Event" (see page 23 for instructions).
- Employee File Upload documents to your Employee File
- Personalized Forms View a confirmation statement for any effective date

Personal Information

Family Information

Beneficiaries

Security Question

Life Event

Employee File

Personalized Forms

User Guide

• The "Online Benefits Website User Guide for Employees" will open in another web window. This provides instructions on how to use MESSA's Online Benefits Website.

NEW HIRE

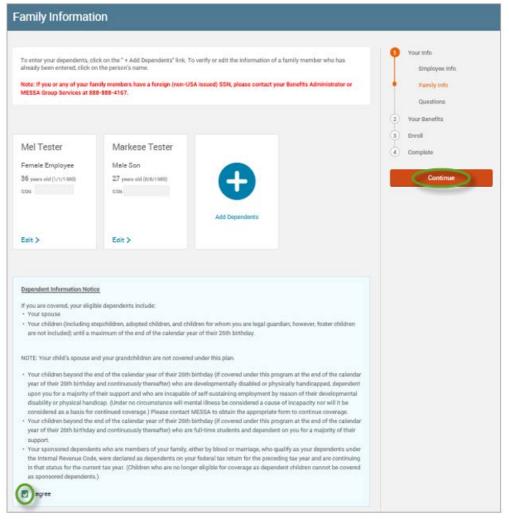
• Click on the "Start Your Enrollment" button to begin.



- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the "I agree" box.
- Click "Continue".

rior to beginning your en elow, or, if the informatio	n has already been entered, make sure it is		
)emographics			
* First Na Middle Init	TEN		
* Last Na			
Sut			
Social Security Num			
* Date of Bi	nth 1/1/1985		
* Gen	der 🔿 Male 🔍 Female		
Gen	ver comune contentate		
* Fields are required			
* Fields are required dress		 0	. Your Info
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dress	1475 Kendale Blvd	•	
dress Address 1		•	Employee Information
dress Address 1 Address 2	1475 Kendale Blvd East Lansing	I	Employee Information Family Info Questions
dress Address 1 Address 2		2	Employee Information Family Info Questions Your Benefits
dress Address 1 Address 2 City	East Lansing	 23	Employee Information Family Info Questions Your Benefits Enroll
dress Address 1 Address 2 City State	East Lansing MI - Michigan	2	Employee Information Family Info Questions Your Benefits
dress Address 1 Address 2 City State Zip	East Lansing MI - Michigan	23	Employee Information Family Info Questions Your Benefits Enroll
dress Address 1 Address 2 City State Zip Home Phone	East Lansing Mi - Michigan 48823 XXX-XXX-XXX-XXXX	23	Employee Information Family Info Questions Your Benefits Enroll Complete
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dress Address 1 Address 2 City State Zip Home Phone Cell Phone Home Email RK CONTACT INFORM Work Phone Ext	East Lansing MI - Michigan 48823 XXX XXXX XXXX XXX XXXX XXXX XXX XXXX XXXX XXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX XXXX	23	Employee Information Family Info Questions Your Benefits Enroll Complete
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- Review/add/edit your Family Information.
- When finished with your Family Information, click the "I agree" box.
- Click "Continue".



NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question "What PAK/Bundle of Coverage do you want?"
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click **"Continue"** on the right-hand side of the screen.

	1 Your Info
*What PAK of Coverage do you want?	T
PAK A Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx Dental - Dent 80/80/80/80:1300(1500)	Employee Information Family Info
Vision - VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000	Questions 2 Your Benefits
PAK B Dental - Dent 80/80/80:1300(1500) Vision - VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D	3 Enroll 4 Complete
PAK C Medical – MESSA ABC Plan 2 Dental - Dent 80/80/80:1300(1500) Vision - VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000	
PAK D Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx Dental - Dent 80/80/80:1300(1500) Vision – VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000	
I want PAK A I want PAK B I want PAK C I want PAK D	
* Fields are required	

• Click on "View Plan Options" to the right of each plan name.

Medical	NO PLAN SELECTED
* Selection Required	View Plan Options

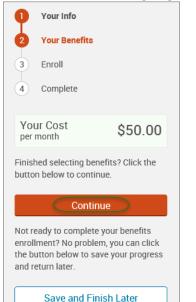
- Once you have clicked on "View Plan Options" you will be presented with the dependent screen. This screen will only appear for the benefits that dependents can be enrolled in.
- To cover a dependent, check the box next to their name.
- To remove a dependent, uncheck the box next to their name.
- Click "Continue".



• Select the benefit plan by clicking "Select".

MESSA ABC Plan 1 w/10% coinsurance, ABC Rx	Your Cost per month:
Blue Cross Blue Shield of Michigan 🛛 High Deductible	\$15.00 💌 Tier: Employee
View plan details	Select
Plan Brochure	Select

• When finished going through every benefit plan, click "**Continue**" on the right-hand side.



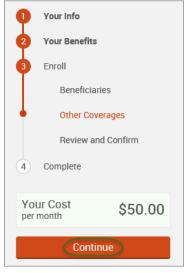
- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also "Add New Beneficiary" if you'd like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click "Continue."

		P Your Info
	ete and accurate before proceeding. ignated in writing and in accordance with the terms of the plan to receive any . "Secondary beneficiary" represents the person or persons named to receive	2 Your Benefits 3 Enroll Beneficiaries
		Other Coverages
Basic Term Life		Review and Confirm
Please choose your beneficiar	es	(4) Complete
Primary Beneficiaries (required)		Your Cost \$50.00
Name	Percentage	
My Estate (Employee)	%	Continue
Sally Test (Spouse)	100 %	
Johnny Test (Son)	%	
 ► Add New Beneficiary ► Add Secondary Beneficiaries (option Secondary beneficiaries receive money if your provide the secondary beneficiaries receive money if your		

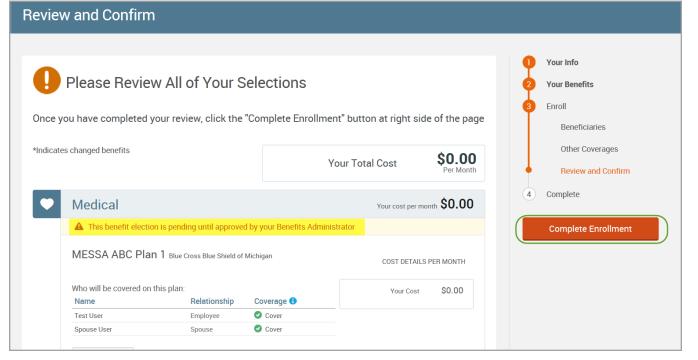
- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click "Yes" next to "Current or Prior Coverages" and enter the following information.
- Once you have entered the information, click "Save."

Medical	
John Test (Employee) Other Medical Insurance Coverage	3-
Current or Prior Coverages Other Insurance	● Yes ○ No New ❤
Policyholder Name	
Policy Number	
Policyholder's Employer	
Policyholder's Employer Address	
Policyholder's Employer Phone	555-555-5555
Insurance Carrier's Name	
Insurance Carrier's Phone	555-555-5555
Coverage Start Date	mm/dd/yyyy
Coverage End Date	mm/dd/yyyy
State/Country of Coverage	~
Coverage Level	Employee
Additional Info	
Save	

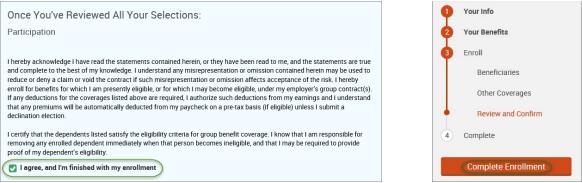
• If you do not have other medical coverage, keep "Current or Prior Coverages" as "No" and click "Continue".



• Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.



- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."



• A Confirmation Statement is presented and you may view, email or print the statement for your records.

Your enrollment is complete! You may make changes to your elections until: September 1, 2017 Please view your enrollment confirmation statement and verify that your selections are correct. Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email"	
 would like to make changes to your enrollment selection, click the "Edit Selection" button located under each p Your Confirmation Statement is ready Your Confirmation Statement is an overview of your new benefits and costs for your review and records. 	Ian.

REMINDER: All benefit elections must be accepted by your Benefits Administrator.

VIEWING/EDITING PERSONAL INFORMATION

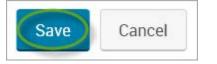
• Click on "My Profile" to see your demographic (personal) information.

1	My Benefits ~	(My Profile)	Library 🗸	User Guide
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• If you need to make changes to any information, click on the "Edit" button next to the panel title that you need to make changes to.

Personal Informa	ation
Demographics	
rior to beginning your enrollme elds below, or, if the informatio	ent, all of your personal and family information must be complete. Please complete the required on has already been entered, make sure it is accurate.
Gabriel Test	
Demographic Information	Edit
First Name	Gabriel
Middle Initial	
Last Name	Test
Suffix	
Social Security Number	
Date of Birth	1/1/1985
Age	32
Gender	Male
Address Information	Edit
Address 1	1475 Kendale Blvd
Address 2	
City	East Lansing
State	MI
Zip	48823
Home Phone	517-332-2581
Cell Phone	
Home Email	
Work Contact Information	1
Work Phone	
Work Phone Ext.	
Work Email	gabrieltest@work.com

• Click **"Save"** once changes are made.



VIEWING/EDITING DEPENDENT INFORMATION

- Click on "My Profile" to see your demographic (personal) information.
- Select "Family Information."

â	My Benefits 🗸	My Profile	Library ~	User Guide
Pers	onal Information			
Fam	ily Information			
Ben	eficiaries			
Secu	urity Question			
Life Event				
Employee File				
Pers	onalized Forms			

• If you need to make changes to your dependent information, click on the "Edit>" button.

Spouse Test	
Male Spouse	
36 years old (1/1/1980)	
SSN:	
Edit >	
• Click "Save" once changes a	are made.
Save & Add Another	Cancel

NOTE: If you need to add or delete dependents to coverage see "Qualifying Events/Enrollment Changes" on page 23.

BENEFICIARIES

When you have life insurance with MESSA, whether it be Negotiated Life Insurance or Optional Life Insurance, a Beneficiary Designation is required. You are able to update beneficiary information without having to make changes to your benefits.



• Click on "Beneficiaries".

	Personal Information
	Family Information
(Beneficiaries
	Security Question
	Life Event
	Employee File
	Personalized Forms

- At least one primary beneficiary for each life insurance policy must be designated.
 - o Basic Term Life & Supplemental Term Life Insurance is entered under the "Basic Term Life" section.
 - Negotiated/PAK & AD&D Life Insurance is entered under the "Negotiated Life" section.
- The dependents that you have listed on your account will automatically be listed.
- Designation percentage must equal 100%.
- Make necessary changes and click "Save".

Beneficiarie	S.	
🛓 Gabriel Test		
	on or entity that is designated as the recipient of signated beneficiaries below.	of funds under your eligible insurance policies. 📑 PRINT
Relationship	Name	
(Employee)	My Estate	
(Spouse)	Paige Test	
(Son)	Jason Test	
Add Beneficiary Beneficiary Desig	Ination	
Basic Term Life		
Beneficiaries		
Name		Percentage
My Estate (Employ	ee)	%
Paige Test (Spouse)	100.0 %
Jason Test (Son)		%
	T	otal: 100%
Negotiated Life		
Beneficiaries		
Name		Percentage
My Estate (Employ	vee)	%
Paige Test (Spous	e)	100.0 %
Jason Test (Son)		%
	T	otal: 100%
✓ Add Second	ary Beneficiaries (optional)	
Save Can	cel	

• You will receive the following message:

Beneficiary Designation information was saved successfully.

- You may add a beneficiary by clicking on the "Add Beneficiary" link.
- The only fields that are required are the "Relationship" and the "Name/Trust Name" fields.
- Once you add a beneficiary, click "Save".
- Now you will be able to designate a percentage to the beneficiary that was added.

Beneficiary Maintenance		
* Relationship	✓	
* Name/Trust Name		
Trust's Full Name		
	Text: no more than 1,000 characters	
Trust Account Number		
Social Security Number	XXX-XX-XXXX	
Date of Birth	(mm/dd/yyyy)	
Home Address 1		
Home Address 2		
City		
State	✓	
Zip		
Phone	XXX-XXX-XXXX	
* Fields are required		
Save & Add	Another Cancel	

QUALIFYING EVENTS / ENROLLMENT CHANGES

- When you have a qualifying event *within 30 days**, a "Life Event" will need to be created to be able to make benefit and/or dependent changes to your policy.
- Directions on how to create a Life Event for each qualifying event are below.
- After creating the Life Event, enrollment MUST be completed in order to make the benefit/dependent changes.

*If the Life Event is outside of MESSA's eligibility guidelines of 30 days, you will need to contact your Benefits Administrator for further assistance.

Birth

• Hover your cursor over the "My Benefits" tab at the top of the screen and choose "Life Events."



• Select "Birth."

Life Events	
💄 Johnny Test	
If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your ben elections. Please fill out all information requested to complete your change in coverage.	efit
STEP 1 Please select your life event	
>Birth	
> Marriage	
Other life events	~

• Enter newborn's birthdate.

STEP 2 Enter your life event information	
Birth	Change life event
When did your life event take place?	
Enter a date (mm/dd/yyyy)	

Select "Add Dependent."

Enter your	new dependent's inform	ation:		
Name	Relationship	Date of Birth	Age	Gender
Add at least	one dependent to continue			
+ Add Dep	endent			
Continue	Cancel			

- Enter newborn's demographic information.
- Click "Save."

Dependent Demographic	
* First Name	
Middle Initial	
* Last Name	
Suffix	
* Date of Birth	07/05/2016
Social Security Number	XXX-XX-XXXX
* Gender	O Male O Female
* Relationship	~
* Fields are required	
Save	

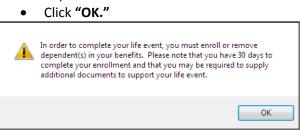
• Click "Continue."

	Enter your new depend	dent's information:			
	Name	Relationship	Date of Birth	Age	Gender
8	Baby Test	Daughter	7/5/2016	0	F
	Add Dependent				
	Continue	cel			

- Check the "I verify that all of the above Life Event information is correct." box.
- Click "Save and Start Life Event Enrollment."

STEP 3 Confirm your information	
Birth	Change life event
Life Event: Birth Date of Event: 07/05/2016 Added to Family: Baby Test	
I verify that all of the above Life Event information is correct.	
Hide Event from Employee	
Save and Start Life Event Enrollment Cancel	

• You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.



- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the "I agree" box.
- Click "Continue".

Employee Inform	nation	
Prior to beginning your enrol	Iment, all of your personal and family information must be complete. Please complete the required fields	
below, or, if the information I	as already been entered, make sure it is accurate.	
Demographics		
* First Name Middle Initia	0.00	
* Last Name		
Suffix Social Security Number		
* Date of Birth	1/1/1985	
* Gender	r ⊖ Male	
* Fields are required Address		1 Your Info
Address 1	1475 Kendale Blvd	Employee Information
Address 2		Family Info
City	East Lansing	Questions
State	MI-Michigan	2 Your Benefits
Zip	MI - Michigan	3 Enroll
Home Phone	46623	(4) Complete
Cell Phone	xxx-xxx	Continue
Home Email		Comme
VORK CONTACT INFORM	ATION	
Work Phone	X004-X004-X000X	
Work Phone Ext.		
* Work Email	testuser@junkmail.com	
Preferred Email	Home Email O Work Email	
* Fields are required		
By checking the box "I Agree" I	below, you agree that the information above is accurate to the best of your knowledge.	
I agree	na na mana na kana na kana kana kana kan	

- Review/add/edit your Family Information.
- When finished with your Family Information, click the "I agree" box.
- Click "Continue".

Family Informa	tion			
been entered, click on the p	amily members have a foreign (non-L			Your Info Employee Information Family Info Questions
John Test Mele Employee 37 years old (1/1/1080) 55%	Sally Test Female Spouce 37 years and (1/1/1980) 55%	Baby Test Female Daughter O years old (6/15/2017)	Johnny Test Male Son 2 years old (1/1/2015) 55%:	Your Benefits Some Second Se
Edit >	Edit >	Edit >	Edit >	
Add Dependents				
			dian; however, foster children are	
NOTE: Your child's spouse a	and your grandchildren are not cover	ed under this plan.		
year of their 26th birthda upon you for a majority o disability or physical han oonsidered as a basis for • Your children beyond the year of their 26th birthda support. • Your sponsored depende the Internal Revenue Cod	end of the calendar year of their 26th y and continuously thereafter) who a if their support and who are incapable dicap. (Under no circumatance will m continued coverage.) Please contac- end of the calendar year of their 26th y and continuously thereafter) who a ents who are members of your family. (e, were declared as dependents on y it tax year. (Children who are no longer	re developmentally disabled or phys or diself-sustaining employment by ental illness be considered a cause (MESSA to obtain the appropriate f hinthday (if covered under this pro- re full-time students and dependent either by blood or marriage, who qu our federal tax return for the preced	ically handicapped, dependent reason of their developmental of incapacity nor will it be form to continue coverage. gram at the end of the calendar con you for a majority of their allfy as your dependents under ing tax year and are continuing in	

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question "What PAK/Bundle of Coverage do you want?"
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click **"Continue"** on the right-hand side of the screen.

	1 Your Info
*What PAK of Coverage do you want?	T
PAK A Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx Dental - Dent 80/80/80/80/1300(1500) Vision - VSP 2S	Employee Information Family Info Questions
Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000	2 Your Benefits 3 Enroll
PAK B Dental - Dent 80/80/80/80:1300(1500) Vision - VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D	4 Complete
PAK C Medical – MESSA ABC Plan 2 Dental - Dent 80/80/80/80:1300(1500) Vision - VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000	
PAK D Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx Dental - Dent 80/80/80/80:1300(1500) Vision – VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000	
O I want PAK B O I want PAK C O I want PAK D	
* Fields are required	

• Click on "View Plan Options" to the right of each plan name.

ullet	Medical			\$35.00 Vour Cost per month
	PLAN	MESSA ABC Plan 1 w/10% View plan details	o coinsurance, ABC Rx	/ Blue Cross Blue Shield of Michigan /
	COVERAGE	Employee + Family		
		Gabriel Test	Employee	Cover
		Paige Test	Spouse	Cover
		Jason Test	Son	Cover
	Completed			View Plan Options

• Check the newborn's name and click "Continue".

Who will be covered b	y this plan?	
	Sally Test Baby Test Johnny Test Add Dependents Spouse Son	
O Back to Benefits		Continue

• Select the benefit plan by clicking "Select" or "Keep Selection".

MESSA ABC Plan 1 w/10% coinsurance, ABC Rx Blue Cross Blue Shield of Michigan High Deductible High Deductible Tie: Employee + Dependent	CURRENT PLAN	
Blue Cross Blue Shield of Michigan 👩 High Deductible	MESSA ABC Plan 1 w/10% coinsurance, ABC Rx	
	Blue Cross Blue Shield of Michigan 🛛 🕅 High Deductible	
Selected	Selected	
View plan details	View plan details	(Keep Selection)
A Plan Brochure	Plan Brochure	

• When finished going through every benefit plan, click "**Continue**" on the right-hand side.

Q	Your Info		
2	Your Benefits		
3	Enroll		
4	Complete		
Your Cost \$50.00			
Finished selecting benefits? Click the button below to continue.			
Continue			
Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.			
Save and Finish Later			

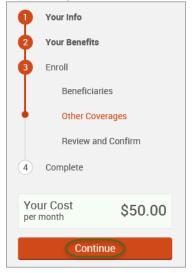
- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also "Add New Beneficiary" if you'd like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click "Continue."

	1 Your Info
Please verify your beneficiary information is complete and accurate before proceeding. "Beneficiary" represents the person or persons designated in writing and in accordance with the terms of the plan to receive any	2 Your Benefits
due benefits after the death of an employee/retiree. "Secondary beneficiary" represents the person or persons named to receive benefits if the primary beneficiary is deceased.	3 Enroll
	Beneficiaries
	Other Coverages
Basic Term Life	Review and Confirm
Please choose your beneficiaries	4 Complete
Primary Beneficiaries (required)	Your Cost \$50.00
Name Percentage	
My Estate (Employee) %	Continue
Sally Test (Spouse) 100 %	
Johnny Test (Son) %	
Total: 100%	
Add New Beneficiary	
✓ Add Secondary Beneficiaries (optional) Secondary beneficiaries receive money if your primary beneficiaries are unable to inherit.	

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click "Yes" next to "Current or Prior Coverages" and enter the following information.
- Once you have entered the information, click "Save."

Medical		
John Test (Employee) Other Medical Insurance Coverage	3-	
Current or Prior Coverages Other Insurance	● Yes ○ No New ✓	
Policyholder Name		
Policy Number		
Policyholder's Employer		
Policyholder's Employer Address		
Policyholder's Employer Phone	555-555-5555	
Insurance Carrier's Name		
Insurance Carrier's Phone	555-555-5555	
Coverage Start Date	mm/dd/yyyy	
Coverage End Date	mm/dd/yyyy	
State/Country of Coverage	✓	
Coverage Level	Employee	
Additional Info		
Save		

• If you do not have other medical coverage, keep "Current or Prior Coverages" as "No" and click "Continue".



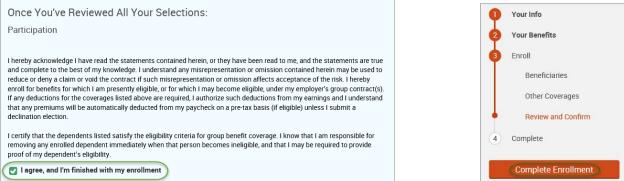
• Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

	Please Review All	of Your S	elections			1	Your Info Your Benefits
	Once you have completed your review, click the "Complete Enrollment" button at right side of the page					3	Enroll Beneficiaries
*Indicates	changed benefits		Ye	our Total Cost	\$0.00 Per Month		Other Coverages Review and Confirm
	Medical			Your cost per mon	nth \$0.00	(4)	Complete
	A This benefit election is pen	ding until approved	l by your Benefits Adminis	trator			Complete Enrollment
	MESSA ABC Plan 1 Blue	Cross Blue Shield of	Michigan	COST DETAILS F	PER MONTH		
	Who will be covered on this plan			Your Cost	\$0.00		
	Name	Relationship	Coverage 🚯				
	Test User Spouse User	Employee Spouse	Cover				
		ορουσε	- 0010				

Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
 On the right side of the screep click "Complete Enrollment "





• A Confirmation Statement is presented and you may view, email or print the statement for your records.

Your enrollment is complete!		
Please view your enrollment confirmation statement and verify that your selections are correct.		
Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Ema would like to make changes to your enrollment selection, click the "Edit Selection" button located under each		
Your Confirmation Statement is ready Your Confirmation Statement is an overview of your new benefits and costs for your review and records.	VIEW MAIL PRINT	

REMINDER: All benefit elections must be accepted by your Benefits Administrator.

Marriage

• Hover your cursor over the "My Benefits" tab at the top of the screen and choose "Life Events."



• Select "Marriage."

Life Events
La Suzy Test
If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.
STEP 1 Please select your life event
> Birth
Marriage
Other life events

• Enter the date of marriage.

STEP 2 Enter your life event information	
Marriage	Change life event
When did your life event take place?	
Enter a date: (mm/dd/yyyy)	

• Select "Add Dependent."

Enter your	new dependent's inform	ation:		
Name	Relationship	Date of Birth	Age	Gender
Add at least	t one dependent to continue			
+ Add Dep	endent			
Continue	e Cancel			

- Enter spouse's demographic information.
- Click "Save."

Add Family Memb	ber
Dependent Demographic	
* First Name	
Middle Initial	
* Last Name	
Suffix	
* Date of Birth	(mm/dd/yyyy)
* Social Security Number	XXX-XX-XXXXX
* Gender	O Male O Female
* Relationship	~
* Fields are required	
Save	

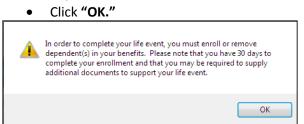
• Click "Continue."

	Enter your new depender	nt's information:			
	Name	Relationship	Date of Birth	Age	Gender
8	Spouse Test	Spouse	1/1/1980	36	Μ
	Add Dependent				
	Continue				

- Check the "I verify that all of the above Life Event information is correct." box.
- Click "Save and Start Life Event Enrollment."

STEP 3 Confirm your information	
Marriage	Change life event
Life Event: Marriage Date of Event: 08/06/2016 Added to Family: Spouse Test	
I verify that all of the above Life Event information is correct.	
Hide Event from Employee Save and Start Life Event Enrollment Cancel	

• You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.



- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the "I agree" box.
- Click "Continue".

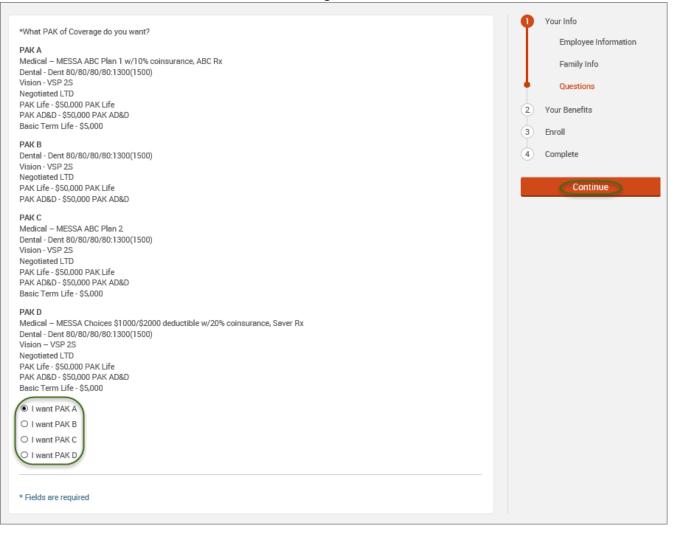
Employee Inforr	nation	
Prior to beginning your enrol below, or, if the information h	ment, all of your personal and family information must be complete. Please complete the required fields as already been entered, make sure it is accurate.	
Demographics		
* First Name Middle Initia * Last Name Suffix Social Security Number * Date of Birth	User	
* Fields are required	O Male	
Address		Your Info
Address 1	1475 Kendale Blvd	Employee Information
Address 2		Family Info
City	East Lansing	Questions
State	MI-Michigan	2 Your Benefits
		3 Enroll
Zip	48823	4 Complete
Home Phone	XXX-XXX-XXXX	
Cell Phone	XXX-XXX-XXXX	Continue
Home Email		
WORK CONTACT INFORM	ATION	
Work Phone	XXX-XXX-XXXX	
Work Phone Ext		
* Work Email	testuser@junkmail.com	
Preferred Email	Home Email O Work Email	
* Fields are required		
By checking the box "I Agree"	below, you agree that the information above is accurate to the best of your knowledge.	

- Review/add/edit your Family Information.
- When finished with your Family Information, click the "I agree" box.
- Click "Continue".

Family Informa	tion			
been entered, click on the po	amily members have a foreign (non-l			Your Info Employee Information Family Info Questions
John Test Male Employee 37 years old (1/1/1088) 55%	Sally Test Female Spouse 37 years and (1/1/1980) 55%	Baby Test Female Daughter O years old (6/15/2017)	Johnny Test Male Son 2 years old (1/1/2015) 55%:	Your Benefits Enroll Gomplete Continue
Edit >	Edit >	Edit >	Edit >	
Add Dependents				
			dian; however, foster children are	
Your children beyond the year of their 26th birthday upon you for a majority of disability or physical han considered as a basis for Your children beyond the	ind your grandchildren are not cover end of the calendar year of their 26t and continuously thereafter) who a f their support and who are incapabli dicap. (Under no circumstance will n continued coverage.) Please contac end of the calendar year of their 26t y and continuously thereafter) who a	h birthday (if covered under this pro re developmentally disabled or phys e of self-sustaining employment by ental illness be considered a cause t MESSA to obtain the appropriate i h birthday (if covered under this pro	ically handicapped, dependent reason of their developmental of incapacity nor will it be form to continue coverage. gram at the end of the calendar	
the internal Revenue Cod	nts who are members of your family, e, were declared as dependents on y t tax year. (Children who are no long	our federal tax return for the preced	ing tax year and are continuing in	

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question "What PAK/Bundle of Coverage do you want?"
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click **"Continue"** on the right-hand side of the screen.



• Click on "View Plan Options" to the right of each plan name.

\bullet	Medical			You	\$35.00 💌 ur Cost per month
	PLAN	MESSA ABC Plan 1 w/10% coinsurance, ABC Rx / Blue Cross Blue Shield of Michigan / View plan details			
	COVERAGE	Employee + Family			
		Gabriel Test	Employee	Cover	
		Paige Test	Spouse	Cover	
		Jason Test	Son	Cover	
	Completed			Vie	w Plan Options

• Check the spouse's name and click "Continue".



• Select the benefit plan by clicking "Select" or "Keep Selection".

	CURRENT PLAN	
	MESSA ABC Plan 1 w/10% coinsurance, ABC Rx	Your Cost per month:
	Blue Cross Blue Shield of Michigan 💀 High Deductible	\$25.00 💌 Tier: Employee + Dependent
Ļ	Selected	
	View plan details	Keep Selection
	Plan Brochure	

• When finished going through every benefit plan, click "**Continue**" on the right-hand side.

Q	Your Info						
2	Your Benefits						
3	Enroll						
4	4 Complete						
	Your Cost per month \$50.00						
	ned selecting ben n below to contin						
	Contin	ue					
Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.							
Save and Finish Later							

- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also "Add New Beneficiary" if you'd like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click "Continue."

		Your Info
Please verify your beneficiary information is comp "Beneficiary" represents the person or persons de due benefits after the death of an employee/retire benefits if the primary beneficiary is deceased.	2 Your Benefits 3 Enroll	
benefits in the primary beneficiary is deceased.		Beneficiaries
		Other Coverages
Basic Term Life		Review and Confirm
Please choose your beneficia	ries	4 Complete
Primary Beneficiaries (required)		Your Cost \$50.00
Name	Percentage	
My Estate (Employee)	%	Continue
Sally Test (Spouse)	100 %	
Johnny Test (Son)	%	
Add New Beneficiary	l: 100%	
✓ Add Secondary Beneficiaries (op Secondary beneficiaries receive money if your		

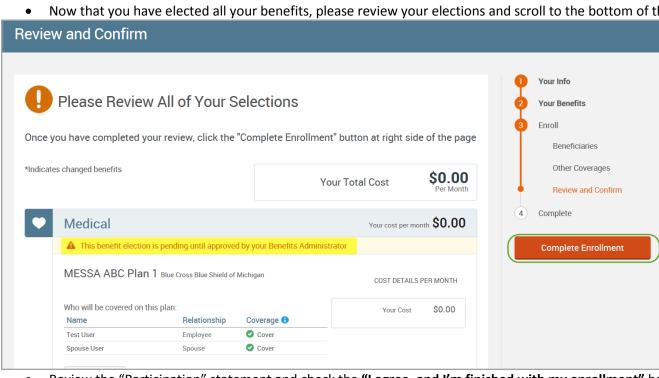
- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click "Yes" next to "Current or Prior Coverages" and enter the following information.
- Once you have entered the information, click "Save."

John Test (Employee) Other Medical Insurance Coverag	e:
Current or Prior Coverages Other Insurance	● Yes ○ No New ✔
Policyholder Name	
Policy Number	
Policyholder's Employer	
Policyholder's Employer Address	
Policyholder's Employer Phone	555-555-5555
Insurance Carrier's Name	
Insurance Carrier's Phone	555-555-5555
Coverage Start Date	mm/dd/yyyy
Coverage End Date	mm/dd/yyyy
State/Country of Coverage	✓
Coverage Level	Employee 🗸
Additional Info	
Save	

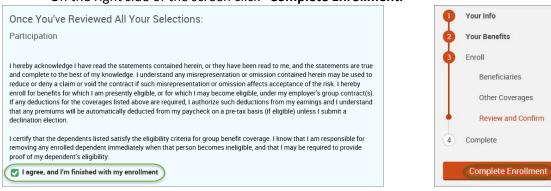
• If you do not have other medical coverage, keep "Current or Prior Coverages" as "No" and click "Continue".



Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

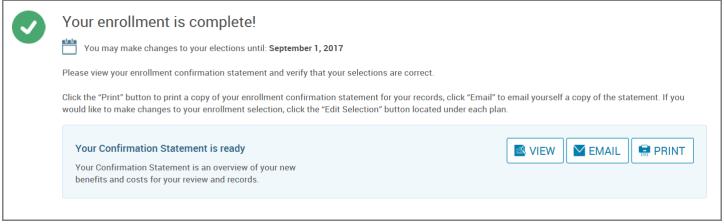


Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box. • On the right side of the screen click "Complete Enrollment." .



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A Confirmation Statement is presented and you may view, email or print the statement for your records.



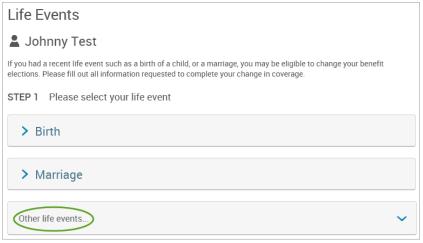
REMINDER: All benefit elections must be accepted by your Benefits Administrator.

Divorce

• Hover your cursor over the "My Benefits" tab at the top of the screen and choose "Life Events."



• Select "Other life events..."



• Select "Divorce."

Life Event

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.					
STEP 1 Please select your life event					
> Birth					
> Marriage					
Other life events					
Legal Guardianship					
Child Becomes Eligible					
Child No Longer Eligible					
Family Status Change - Other					

• Enter the date of divorce.

STEP 2 Enter your life event information	
Divorce	Change life event
When did your life event take place?	
Enter a date (mm/dd/yyyy)	

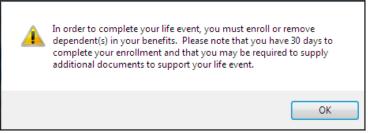
- Check the box next to the spouse's name.
- Click "Continue."

Update	Name	SSN	Relationship	Date of Birth	Age	Gender	Additional Information
	Joe Test		Employee	1/1/1980	36	М	
	Spouse Test		Spouse	1/1/1980	36	F	
	Michael Test		Son	1/1/1989	27	м	

- Check the "I verify that all of the above Life Event information is correct." box.
- Click "Save and Start Life Event Enrollment."

STEP 3 Confirm your information	
Divorce	Change life event
Life Event: Divorce	
Date of Event: 08/05/2016	
Removed from Family: Spouse Test	
I verify that all of the above Life Event information is correct.	
Hide Event from Employee	
Save and Start Life Event Enrollment Cancel	

- You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.
- Click "OK."



- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the "I agree" box.
- Click "Continue".

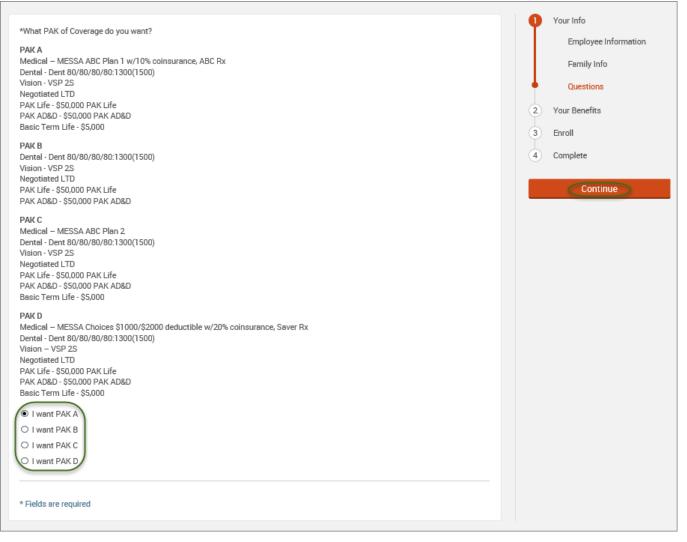
Employee Inform	nation		
Prior to beginning your enroll below, or, if the information h	ment, all of your personal and family information must be complete. Please complete the required fields as already been entered, make sure it is accurate.		
Demographics			
* First Name Middle Initial * Last Name Suffix Social Security Number * Date of Birth * Gender	User		
* Fields are required			
Address		- 9	Your Info
Address 1	1475 Kendale Blvd	•	Employee Information
Address 2			Family Info
City	East Lansing		Questions
		2	Your Benefits
State	MI - Michigan	Ĭ	
Zip	48823	3	Enroll
Home Phone	xxx-xxxx	4	Complete
Cell Phone	XXX-XXXX		Continue
Home Email			
WORK CONTACT INFORMA	ATION		
Work Phone	XXX-XXXX		
Work Phone Ext.			
* Work Email	testuser@junkmail.com		
Preferred Email	Home Email O Work Email		
* Fields are required			
By checking the box "I Agree" I	below, you agree that the information above is accurate to the best of your knowledge.		

- Review/add/edit your Family Information.
- When finished with your Family Information, click the "I agree" box.
- Click "Continue".

	ition			
been entered, click on the p	family members have a foreign (non-L			Your Info Employee Information Family Info Questions
John Test Male Employee 37 years old (1/1/1080) 55%	Sally Test Female Spouce 37 years and (1/1/1980) 55%	Baby Test Female Daughter O years old (6/16/2017)	Johnny Test Male Son 2 years old (1/1/2015) SSN:	Your Benefits Omplete Continue
Edit >	Edit >	Edit >	Edit >	
Add Dependents	tice			
Dependent Information No				
- If you are covered, your eliq • Your spouse • Your children (including	pible dependents include: stepchildren, adopted children, and of simum of the end of the calendar year		lian; however, foster children are	
If you are covered, your elig • Your spouse • Your children (including not included) until a man	stepchildren, adopted children, and of	of their 26th birthday.	dian; however, foster children are	

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

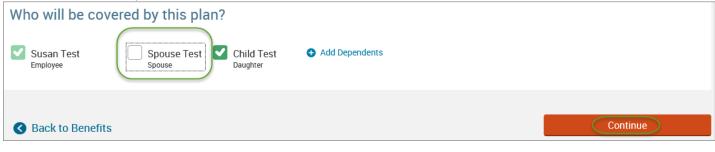
- You will be presented with the question "What PAK/Bundle of Coverage do you want?"
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click **"Continue"** on the right-hand side of the screen.



• Click on "View Plan Options" to the right of each plan name.

Medical			You	\$35.00 💌	
PLAN	MESSA ABC Plan 1 w/10 View plan details	% coinsurance, ABC	Rx / Blue Cross Blue Shield of	Michigan /	
COVERAGE	Employee + Family	mployee + Family			
	Gabriel Test	Employee	Cover		
	Paige Test	Spouse	Cover		
	Jason Test	Son	Cover		
Completed			Vie	w Plan Options	

• Uncheck the spouse's name and click "Continue".



• Select the benefit plan by clicking "Select" or "Keep Selection".

Your Cost per month:
\$25.00 Tier: Employee + Dependent
Keep Selection

• When finished going through every benefit plan, click "**Continue**" on the right-hand side.

Ψ.	Your Info	
2	Your Benefits	5
3	Enroll	
4	Complete	
	ur Cost month	\$50.00
	ned selecting b n below to con	enefits? Click the tinue.
	n below to con	
butto Not re enroll the bi	n below to con Cont eady to comple Iment? No prob	tinue.
Not re enroll	n below to con Cont eady to comple liment? No prob utton below to eturn later.	tinue. tinue ete your benefits elem, you can click

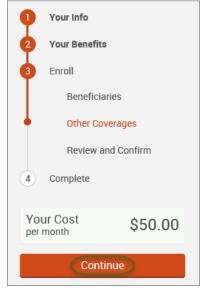
- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also "Add New Beneficiary" if you'd like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click "Continue."

		P Your Info
Please verify your beneficiary information is comp "Beneficiary" represents the person or persons der due benefits after the death of an employee/retire benefits if the primary beneficiary is deceased.	2 Your Benefits 3 Enroll	
beneficia n'are primary beneficiary is deceased.		Beneficiaries
		Other Coverages
Basic Term Life		Review and Confirm
Please choose your beneficial	ies	4 Complete
Primary Beneficiaries (required)		Your Cost \$50.00
Name	Percentage	
My Estate (Employee)	%	Continue
Sally Test (Spouse)	100 %	
Johnny Test (Son)	%	
Add New Beneficiary	l: 100%	
✓ Add Secondary Beneficiaries (opt Secondary beneficiaries receive money if your		

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click "Yes" next to "Current or Prior Coverages" and enter the following information.
- Once you have entered the information, click "Save."

Medical	
John Test (Employee) Other Medical Insurance Coverage	a.
Current or Prior Coverages Other Insurance	● Yes ○ No New ~
Policyholder Name	
Policy Number	
Policyholder's Employer	
Policyholder's Employer Address	
Policyholder's Employer Phone	555-555-5555
Insurance Carrier's Name	
Insurance Carrier's Phone	555-555-5555
Coverage Start Date	mm/dd/yyyy
Coverage End Date	mm/dd/yyyy
State/Country of Coverage	~
Coverage Level	Employee 💙
Additional Info	
Save	

• If you do not have other medical coverage, keep "Current or Prior Coverages" as "No" and click "Continue".



• Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

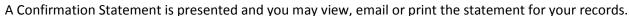
Review and Confirm

						•	Your Info
IJ	Please Revie	w All of Your S	Selections			2	Your Benefits
						3	Enroll
nce y	ou have completed y	your review, click the	"Complete Enrollment" t	outton at right si	ide of the page		Beneficiaries
ndicate	es changed benefits				<u> </u>		Other Coverages
			Your	Total Cost	\$0.00 Per Month	•	Review and Confirm
$\mathbf{\bullet}$	Medical			Your cost per r	month \$0.00	4	Complete
	A This benefit election	on is pending until approve	d by your Benefits Administrate	or			Complete Enrollment
	MESSA ABC Pla	n 1 Blue Cross Blue Shield of	Michigan	COST DETAIL	LS PER MONTH		
	Who will be covered on	this plan:		Your Cost	\$0.00		
	Name	Relationship	Coverage 🚯				
	Test User	Employee	Over				
	Spouse User	Spouse	Over				

• Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.







0	Your enrollment is complete! You may make changes to your elections until: September 1, 2017 Please view your enrollment confirmation statement and verify that your selections are correct. Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Emai would like to make changes to your enrollment selection, click the "Edit Selection" button located under each	
	Your Confirmation Statement is ready Your Confirmation Statement is an overview of your new benefits and costs for your review and records.	🛯 VIEW 🔄 EMAIL 😭 PRINT

REMINDER: All benefit elections must be accepted by your Benefits Administrator.

Legal Guardianship

• Hover your cursor over the "My Benefits" tab at the top of the screen and choose "Life Events."



• Select "Other life events..."

Life Events

💄 Johnny Test

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event	
> Birth	
> Marriage	
Other life events	~

• Select "Legal Guardianship."

Life Event
If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.
STEP 1 Please select your life event
> Birth
> Marriage
Other life events
Divorce
Legal Guardianship
Child Becomes Eligible
Child No Longer Eligible
Family Status Change - Other

• Enter legal guardianship effective date.

STEP 2 Enter your life event information	
Legal Guardianship	Change life event
When did your life event take place?	
Enter a date (mm/dd/yyyy)	

• Select "Add Dependent."

Enter your new dependent's information:						
Name	Relationship	Date of Birth	Age	Gender		
Add at least	one dependent to continue					
Add Dependent						
Continue	Cancel					

- Enter legal guardian's demographic information
- Click "Save."

Add Family Memb	ber
Dependent Demographic	
* First Name	
Middle Initial	
* Last Name	
Suffix	
* Date of Birth	(mm/dd/yyyy)
* Social Security Number	XXX-XX-XXXX
* Gender	O Male O Female
* Relationship	~
* Fields are required	
Save	

• Click "Continue."

	Name	Relationship	Date of Birth	Age	Gender
8	Legal Guardian	Legal Guardianship	1/1/1999	17	Μ
	Add Dependent				
	Continue				

- Check the "I verify that all of the above Life Event information is correct." box.
- Click "Save and Start Life Event Enrollment."

STEP 3 Confirm your information	
Legal Guardianship	Change life event
Life Event: Legal Guardianship Date of Event: 08/01/2016	
Added to Family: Legal Guardian	
Hide Event from Employee	
Save and Start Life Event Enrollment Cancel	

- You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.
- Click "OK."

<u>^</u>	In order to complete your life event, you must enroll or remove dependent(s) in your benefits. Please note that you have 30 days to complete your enrollment and that you may be required to supply additional documents to support your life event.
	ок

- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the "I agree" box.
- Click "Continue".

Employee Info	mation			
	ollment, all of your personal and family infor has already been entered, make sure it is a	nation must be complete. Please complete the required fields curate.		
Demographics				
* First Nar Middle Init	1100			
* Last Nar Suf	000			
Social Security Numb	er			
* Date of Bir	(1) (1) (300			
	er ○ Male ● Female			
* Fields are required ddress			0	Your Info
Address 1			T	Employee Information
	1475 Kendale Blvd			
Address 2				Family Info
City	East Lansing			Questions
State	MI - Michigan 🗸		2	Your Benefits
Zip	48823	8	3	Enroll
Home Phone			4	Complete
Cell Phone	XXX-XXX-XXXX			
Home Email			C	Continue
ORK CONTACT INFORM	ATION			
Work Phone	xxx-xxx-xxxx			
		- -		
Work Phone Ext.				
Work Phone Ext. * Work Email	testuser@junkmail.com			
* Work Email	testuser@junkmail.com • Home Email O Work Email			
* Work Email				
* Work Email Preferred Email				

- Review/add/edit your Family Information.
- When finished with your Family Information, click the "I agree" box.
- Click "Continue".

o enter vour dependente vi	ick on the " + Add Dependents" link	To unify or add the information of	family member who has alwayly	Your info
o enter your dependents, o een entered, click on the pr	ick on the " + Add Dependents" link. rson's name.	to verify or edit the intomitation of a	ranwy memoer who has already	Employee Information
	mity members have a foreign (non-l	USA issued) SSN, please contact yo	ur Benefits Administrator or	Family Info
ESSA Group Services at 8	8-888-4167.			Questions
				(2) Your Benefits
				(3) Enroll
lohn Test	Sally Test	Baby Test	Johnny Test	(4) Complete
lale Employee	Female Spouge	Female Daughter	Male Son	
7 years old (1/1/1080)	37 years old (1/1/1980)	0 years old (6/1 5/2017)	2 years old (1/1/2015)	Continue
54	55%		559:	
dit >	Edit >	Edit >	Edit >	
un y	Cont /	carty	con /	
Add Dependents				
Add Dependents				
Add Dependents	26			
egendent Information Noti				
ependent Information Noti you are covered, your eligi Your spouse		hildren for whom you are legal ouar	slan; however, foster children are	
ependent Information Noti you are covered, your eligi Your spouse Your children (including s	ble dependents include:		slan; however, foster children are	
sgendent Information Noti you are covered, your eligi Your spouse Your children (including s not included) until a maxi	ble dependents include: tepchildren, adopted children, and cl	of their 26th birthday.	slan; however, foster children are	
egendent information Noti you are covered, your eligi Your spouse Your children (including s not included) until a maxi IOTE: Your child's spouse a Your children beyond the	ble dependents include: tepchildren, adopted children, and o mum of the end of the calendar year nd your grandchildren are not cover end of the calendar year of their 26t	of their 25th birthday. ed under this plan. h birthday (if covered under this pro	gram at the end of the calendar	
spendent Information Noti you are covered, your eligi Your shusse Your children (including s not included) until a maxi IOTE: Your child's spouse a Your children beyond the year of their 26th birthday	ble dependents include: tepchildren, adopted children, and cl mum of the end of the calendar year nd your grandchildren are not cover and of the calendar year of their 26t r and continuously thereafter) who a	r of their 25th birthday. ed under this plan. h birthday (if covered under this pro re developmentally disabled or phys	gram at the end of the caleedar ically handicapped, dependent	
egendent Information Noti you are covered, your eligi Your spouse Your children (including s not included) until a maxi IOTE: Your child's spouse a Your children beyond the year of their 26th birthday upon you for a majority of disability or physical hans	ble dependents include: tepchildren, adopted children, and ol mum of the end of the calendar year and your grandchildren are not cover and of the calendar year of their 26ti r and continuously thereafter) who a their support and who are incapabli ticap. (Under no circumstance will m	of their 25th birthday. ed under this plan. h birthday (if covered under this pro re developmentally disabled or phy e of self-sustaining employment by vental illness be considered a cause	gram at the end of the caleedar ically handicapped, dependent reason of their developmental of incapacity nor will it be	
agendent Information Noti you are covered, your eligi Your apouse Your children (including a not included) until a maxi ICITE: Your children beyond the year of their 26th birthday upon you for a majority of disability or physical hans considered as a basis for Your children beyond the year of their 26th birthday	ble dependents include: tepchildren, adopted children, and cl mum of the end of the calendar year nd your grandchildren are not cover end of the calendar year of their 28tt rand continuously thereafter) who a 'their support and who are incapabl	of their 28th birthday. ed under this plan. h birthday (if covered under this pro re developmentally disabled or phys e of self-sustaining employment by neutal (likess be considered a cause t MESSA to obtain the appropriate i h birthday (if covered under this pro	gram at the end of the calendar ically handicapped, dependent reason of their developmental of incapacity nor will it be form to continue coverage. gram at the end of the calendar	
espendent Information Noti you are covered, your eligi Your spouse Your children (including s not included) until a massi IOTE: Your child's spouse a Your children beyond the year of their 26th birthday upon you for a majoitty of disability or physical hans considered as a basis for Your children beyond the year of their 26th birthday support.	ble dependents include: tepchildren, adopted children, and cl mum of the end of the calendar year nd your grandchildren are not cover and of the calendar year of their 26ti r and continuously thereafter) who a their support and who are incapabl- bicap. (Under no circumstance will m continued coverage.) Please contact and of the calendar year of their 26ti	of their 28th birthday. ed under this plan. h birthday (if covered under this pro re developmentally disabled or phy e of self-sustaining employment by nental illness be considered a cause t MESSA to obtain the appropriate i h birthday (if covered under this pro re full-time students and dependent	gram at the end of the calendar ically handicapped, dependent reason of their developmental of incapacity nor will it be form to continue coverage. gram at the end of the calendar on you for a majority of their	
Pependent Information Noti f you are covered, your eligi • Your spouse • Your children (including s not included) until a maxi ADTE: Your childra spouse a • Your children beyond the year of their 25th birthday upon you for a majority of disability or physical ham considered as a basis for • Your children beyond the year of their 25th birthday support. • Your sponsored dependent the internal Revenue Cod	ble dependents include: tepchildren, adopted children, and cl mum of the end of the calendar year and your grandchildren are not cover end of the calendar year of their 26t and continuously thereafter) who a their support and who are incapabli ficap. (Under no circumstance will re continued coverage.) Please contac end of the calendar year of their 26t and continuously thereafter) who a	of their 25th birthday. ed under this plan. h birthday (if covered under this pro- re developmentally disabled or phy- tental illnees be considered a cause t MESSA to obtain the appropriate (h birthday (if covered under this pro- re full-time students and dependent either by blood or matriage, who qu our federal tax return for the preced	gram at the end of the caleedar rically handicapped, dependent reason of their developmental of incapacity nor will it be form to continue coverage. gram at the end of the caleedar on you for a majority of their alify as your dependents under ing tax year and are continuing in	

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question "What PAK/Bundle of Coverage do you want?"
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click **"Continue"** on the right-hand side of the screen.

	A Maria Infa
*What PAK of Coverage do you want?	1 Your Info
PAK A Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx Dental - Dent 80/80/80/80/30(1500) Vision - VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000	Employee Information Family Info Questions 2 Your Benefits 3 Enroll
PAK B Dental - Dent 80/80/80/80:1300(1500) Vision - VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D	4 Complete
PAK C Medical – MESSA ABC Plan 2 Dental - Dent 80/80/80/80/1500) Vision - VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000	
PAK D Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx Dental - Dent 80/80/80/80:1300(1500) Vision – VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000	
I want PAK A I want PAK B I want PAK C I want PAK D	
* Fields are required	

• Click on "View Plan Options" to the right of each plan name.

Medical				\$35.00 Vour Cost per month
PLAN	MESSA ABC Plan 1 View plan details	w/10% coinsurance, AB	C Rx / Blue Cross Blue Shi	eld of Michigan /
COVERAGE	Employee + Family			
	Gabriel Test	Employee	🕑 Cover	
	Paige Test	Spouse	Cover	
	Jason Test	Son	Cover	
Completed	Juson rest	501		View Plan Options

• Check the legal guardian's name and click "Continue".

Who will be cover	red by this pla	an?			
Susan Test Employee	Spouse Test Spouse	Child Test Daughter	Mark Tester Legal Guardianship	Add Dependents	
S Back to Benefits					Continue

• Select the benefit plan by clicking "Select" or "Keep Selection".



• When finished going through every benefit plan, click "**Continue**" on the right-hand side.

Q	Your Info				
2	Your Benefit	is			
3	Enroll				
4	Complete				
	ur Cost month	\$50.00			
	n below to co				
	Cor	ntinue			
Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.					
	Save and	Finish Later			

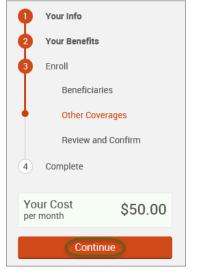
- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also "Add New Beneficiary" if you'd like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click "Continue."

		P Your Info
	lete and accurate before proceeding. signated in writing and in accordance with the terms of the plan to receive any e. "Secondary beneficiary" represents the person or persons named to receive	2 Your Benefits 3 Enroll
beneficia n'are primary beneficiary is deceased.		Beneficiaries
		Other Coverages
Basic Term Life		Review and Confirm
Please choose your beneficial	ies	4 Complete
Primary Beneficiaries (required)		Your Cost \$50.00
Name	Percentage	
My Estate (Employee)	%	Continue
Sally Test (Spouse)	100 %	
Johnny Test (Son)	%	
Add New Beneficiary	l: 100%	
✓ Add Secondary Beneficiaries (opt Secondary beneficiaries receive money if your		

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click "Yes" next to "Current or Prior Coverages" and enter the following information.
- Once you have entered the information, click "Save."

John Test (Employee) Other Medical Insurance Coverag	e:
Current or Prior Coverages Other Insurance	● Yes ○ No New ✔
Policyholder Name	
Policy Number	
Policyholder's Employer	
Policyholder's Employer Address	
Policyholder's Employer Phone	555-555-5555
Insurance Carrier's Name	
Insurance Carrier's Phone	555-555-5555
Coverage Start Date	mm/dd/yyyy
Coverage End Date	mm/dd/yyyy
State/Country of Coverage	~
Coverage Level	Employee 🗸
Additional Info	
Save	

• If you do not have other medical coverage, keep "Current or Prior Coverages" as "No" and click "Continue".

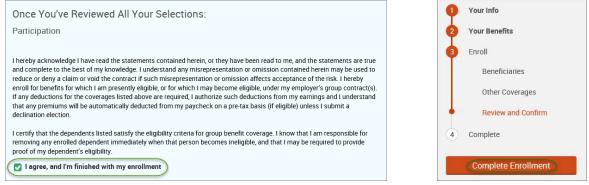


Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page. •

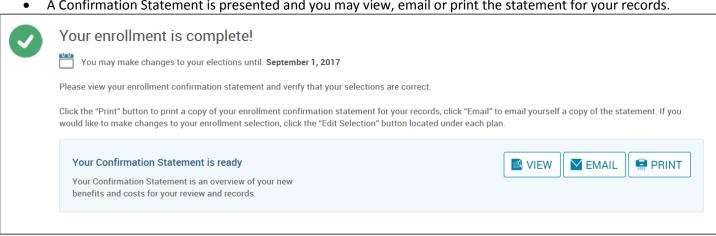
Review and Confirm

							9	Your Info
9	Please Revie	w All of Your S	selections				2	Your Benefits
							3	Enroll
nce yo	ou have completed y	your review, click the	"Complete Enrol	lment" button a	t right sid	e of the page		Beneficiaries
dicates	s changed benefits					¢0.00		Other Coverages
				Your Total Co	ost	\$0.00 Per Month	4	Review and Confirm
	Medical					nth \$0.00	4	Complete
	Medical			Yo	ur cost per mo	nth 30.00		
	A This benefit election	on is pending until approve	d by your Benefits Ac	Iministrator				Complete Enrollment
	MESSA ABC Pla	${\sf n}$ 1 Blue Cross Blue Shield of	Michigan	(COST DETAILS	PER MONTH		
	Who will be covered on	this plan:			Your Cost	\$0.00		
	Name	Relationship	Coverage 🕤					
	Test User	Employee	Cover					
	Spouse User	Spouse	Cover					

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."



A Confirmation Statement is presented and you may view, email or print the statement for your records.



REMINDER: All benefit elections must be accepted by your Benefits Administrator. Adding a Dependent

• Hover your cursor over the "My Benefits" tab at the top of the screen and choose "Life Events."

My Benefits 🗸	
Current Benefits	
Life Events	
• Select "Other life	e events"

Life Events	
💄 Johnny Test	
If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.	
STEP 1 Please select your life event	
> Birth	
> Marriage	
Other life events	~

• Select "Child Becomes Eligible."

Life Event

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event	
> Birth	
> Marriage	
Other life events	~
Divorce	
Legal Guardianship Child Becomes Eligible	
Child No Longer Eligible	
Family Status Change - Other	

• Enter the effective date (first of the month).

STEP 2 Enter your life event information	
Child Becomes Eligible	Change life event
When did your life event take place?	
Enter a date:) (mm/dd/yyyy)	

- Check the "I verify that all of the above Life Event information is correct." box.
- Click "Save and Start Life Event Enrollment."

STEP 3 Confirm your information	
Child Becomes Eligible	Change life event
Life Event: Child Becomes Eligible Date of Event: 08/01/2016	
I verify that all of the above Life Event information is correct.	
Hide Event from Employee	
Save and Start Life Event Enrollment Cancel	

- You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.
- Click "OK."

 In order to complete your life event, you must enroll or remove dependent(s) in your benefits. Please note that you have 30 days to complete your enrollment and that you may be required to supply additional documents to support your life event.

 OK

- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the "I agree" box.
- Click "Continue".

Employee Inform	nation	
	iment, all of your personal and family information must be complete. Please complete the required fields has already been entered, make sure it is accurate.	
Demographics * First Name Middle Initial * Last Name Suffix Social Security Number * Date of Birth * Gender * Fields are required	User	
Address 1 Address 2 City State Zip Home Phone Cell Phone Home Email WORK CONTACT INFORM/ Work Phone Ext. *Work Email Preferred Email	xxx-xxxx testuser@junkmail.com	Your Info Employee Information Family Info Questions Your Benefits Enroll Complete Continue
By checking the box "I Agree" I	below, you agree that the information above is accurate to the best of your knowledge.	

- Review/add/edit your Family Information.
- When finished with your Family Information, click the "I agree" box.
- Click "Continue".

Family Informat	ion			
been entered, click on the pe	mily members have a foreign (non-l			Your Info Employee Information Family Info Questions
John Test Male Employee 37 years add (1/1/1080) 55%	Sally Test Female Spouce 37 years and (1/1/1980) Stre	Baby Test Female Daughter O years old (6/15/2017)	Johnny Test Male Son 2 years cid (1/1/2015) SSN:	Your Benefits Ocomplete Continue
Edit >	Edit >	Edit >	Edit >	
Add Dependents				
			dian; however, foster children are	
Your children beyond the year of their 26th birthday upon you for a majority of disability or physical hand considered as a basis for . Your children beyond the r	nd your grandchildren are not cover end of the calendar year of their 26t and continuounly thereafter) who a their support and who are incapabl- licap. (Under no circumstance will n continued coverage.) Please contac end of the calendar year of their 26t and continuouusly thereafter) who a	h birthday (if covered under this pro re developmentally disabled or phys e of self-sustaining employment by vental illness be considered a cause t MESSA to obtain the appropriate i h birthday (if covered under this pro	ically handicapped, dependent reason of their developmental of incapacity nor will it be form to continue coverage. gram at the end of the calendar	
the Internal Revenue Code	its who are members of your family, , were declared as dependents on y tax year. (Children who are no long	our federal tax return for the preced	ing tax year and are continuing in	

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question "What PAK/Bundle of Coverage do you want?"
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click **"Continue"** on the right-hand side of the screen.

	1 Your Info
*What PAK of Coverage do you want?	Employee Information
PAK A Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx Dental - Dent 80/80/80:1300(1500)	Family Info
Vision - VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D	Questions Vour Benefits
Basic Term Life - \$5,000	3 Enroll
PAK B Dental - Dent 80/80/80:1300(1500) Vision - VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D	4 Complete
PAK C Medical – MESSA ABC Plan 2 Dental - Dent 80/80/80:1300(1500) Vision - VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000	
PAK D Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx Dental - Dent 80/80/80/1300(1500) Vision – VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000	
 I want PAK A I want PAK B I want PAK C I want PAK D 	
* Fields are required	

• Click on "View Plan Options" to the right of each plan name.

Medical				\$35.00 Vour Cost per month
PLAN	MESSA ABC Plan 1 View plan details	w/10% coinsurance, AB0	C Rx / Blue Cross Blue Shiel	d of Michigan /
COVERAGE	Employee + Family	r		
	Gabriel Test	Employee	Cover	
	Paige Test	Spouse	Cover	
	Jason Test	Son	Over	
Completed				View Plan Options

• Check the dependent's name and click "Continue".

Who will be cover	ed by this plan?	
Susan Test Employee	Spouse Test Child Test Daughter Mark Tester Legal Guardianship	
Seck to Benefits		Continue

• Select the benefit plan by clicking "Select" or "Keep Selection".

CURRENT PLAN	
MESSA ABC Plan 1 w/10% coinsurance, ABC Rx	Your Cost per month:
Blue Cross Blue Shield of Michigan 👔 High Deductible	\$25.00 V Tier: Employee + Dependent
Selected	
View plan details	Keep Selection
😓 Plan Brochure	

• When finished going through every benefit plan, click "**Continue**" on the right-hand side.

•	Your Info		
2	Your Benefit	ts	
3	Enroll		
4	Complete		
	ur Cost	\$50.00	
Finished selecting benefits? Click the button below to continue.			
	Cor	ntinue	
enroll the bu	ment? No pro	lete your benefits Iblem, you can click o save your progress	
	Save and	Finish Later	

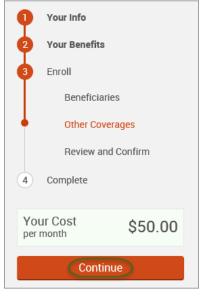
- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also "Add New Beneficiary" if you'd like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click "Continue."

		T Your Info	
Please verify your beneficiary informatio "Beneficiary" represents the person or pe	of the plan to receive any		
due benefits after the death of an employ benefits if the primary beneficiary is dec	vee/retiree. "Secondary beneficiary" represents the person or pe eased	persons named to receive	
		Beneficiaries	
		Other Coverage	s
Basic Term Life		Review and Cor	ıfirm
Please choose your ben	eficiaries	4 Complete	
Primary Beneficiaries (requir	<mark>ed)</mark>	Your Cost per month	\$50.00
Name	Percentage		
My Estate (Employee)	%	Continue	
Sally Test (Spouse)	100 %		
Johnny Test (Son)	%		
	Total: 100%		
Add New Beneficiary			
 Add Secondary Beneficiarie Secondary beneficiaries receive mono 	es (optional) y if your primary beneficiaries are unable to inherit.		

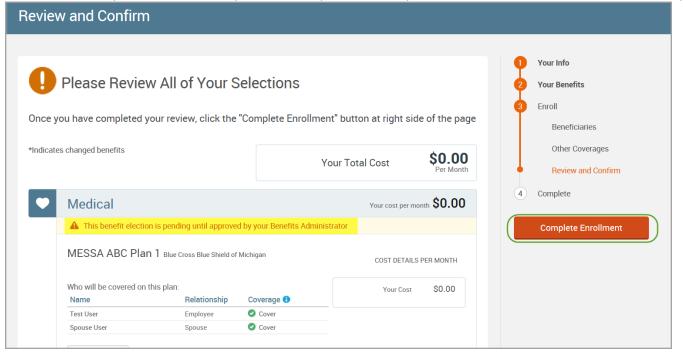
- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click "Yes" next to "Current or Prior Coverages" and enter the following information.
- Once you have entered the information, click "Save."

Medical		
John Test (Employee) Other Medical Insurance Coverage	e.	
Current or Prior Coverages Other Insurance	● Yes ○ No New ▼	
Policyholder Name		
Policy Number		
Policyholder's Employer		
Policyholder's Employer Address		
Policyholder's Employer Phone	555-555-5555	
Insurance Carrier's Name		
Insurance Carrier's Phone	555-555-5555	
Coverage Start Date	mm/dd/yyyy	
Coverage End Date	mm/dd/yyyy	
State/Country of Coverage	~	
Coverage Level	Employee 🗸	
Additional Info		
Save		

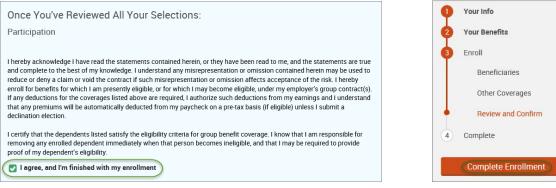
• If you do not have other medical coverage, keep "Current or Prior Coverages" as "No" and click "Continue".



• Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.



- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."



• A Confirmation Statement is presented and you may view, email or print the statement for your records.

	Your enrollment is complete! You may make changes to your elections until: September 1, 2017 Please view your enrollment confirmation statement and verify that your selections are correct. Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email would like to make changes to your enrollment selection, click the "Edit Selection" button located under each p		
	Your Confirmation Statement is ready Your Confirmation Statement is an overview of your new benefits and costs for your review and records.	VIEW MAIL PRINT	

REMINDER: All benefit elections must be accepted by your Benefits Administrator.

Removing a Dependent from ALL Benefits

• Hover your cursor over the "My Benefits" tab at the top of the screen and choose "Life Events."



• Select "Other life events..."

Life Events			
💄 Johnny Test			
If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.			
STEP 1 Please select your life event			
> Birth			
> Marriage			
Other life events			

• Select "Child No Longer Eligible."

Life Event				
If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.				
STEP 1 Please select your life event				
> Birth				
> Marriage				
Other life events 🗸				
Divorce				
Legal Guardianship				
Child Becomes Eligible				
Child No Longer Eligible				
Family Status Change - Other				

• Enter the effective date (last day of the month in which coverage is ending).

STEP 2 Enter your life event information	
Child No Longer Eligible	Change life event
When did your life event take place?	
Enter a date: (mm/dd/yyyy)	

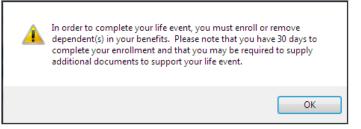
- Check the box next to the dependent's name.
- Click "Continue."

Update	Name	SSN	Relationship	Date of Birth	Age	Gender	Additional Information
	Joe Test		Employee	1/1/1980	36	М	
	Spouse Test		Spouse	1/1/1980	36	F	Divorced
	Michael Test		Son	1/1/1989	27	М	

- Check the "I verify that all of the above Life Event information is correct." box.
- Click "Save and Start Life Event Enrollment."

STEP 3 Confirm your information	
Child No Longer Eligible	Change life event
Life Event: Child No Longer Eligible	
Date of Event: 08/31/2016	
Removed from Family: Michael Test	
I verify that all of the above Life Event information is correct.	
Hide Event from Employee	
Cancel	

- You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.
- Click "OK."



- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the "I agree" box.
- Click "Continue".

Employee Inform	nation		
	Iment, all of your personal and family information must be complete. Please complete the required fields as already been entered, make sure it is accurate.	5	
Demographics * First Name Middle Initial * Last Name Suffix Social Security Number * Date of Birth * Gender	User		
Address		0	Your Info
Address 1 Address 2 City	1475 Kendale Blvd East Lansing		Employee Information Family Info Questions
State	MI - Michigan	2	Your Benefits Enroll
Zip Home Phone	48823	4	Complete
Cell Phone	xxx-xxx-xxxx		Continue
Home Email			
WORK CONTACT INFORM	ATION		
Work Phone	XXX-XXXX-XXXXX		
Work Phone Ext.			
* Work Email	testuser@junkmail.com		
Preferred Email	Home Email O Work Email		
* Fields are required			
By checking the box "I Agree" I	below, you agree that the information above is accurate to the best of your knowledge.		

- Review/add/edit your Family Information.
- When finished with your Family Information, click the "I agree" box.
- Click "Continue".

Family Informa	tion			
To enter your dependents o	fick on the " + Add Dependents" link.	To verify or edit the information of a	a family member who has already	Your info
been entered, click on the p	Employee Information Family Info			
MESSA Group Services at 8	60° 808° 4187.			Questions 2 Your Benefits
				3 Enroll
John Test	Sally Test	Baby Test	Johnny Test	(4) Complete
Male Employee 37 years old (1/1/1080)	Female Spouse 37 years and (1/1/1980)	Female Daughter O years old (6/15/2017)	Male Son 2 years old (1/1/2015)	Continue
55%	594		59N:	
Edit >	Edit >	Edit >	Edit >	
Add Dependents Dependent Information Not If you are covered, your elig				
 Your spouse Your children (including state) 	stepchildren, adopted children, and of imum of the end of the calendar year		dian; however, foster children are	
NDTE: Your child's spouse a	and your grandchildren are not cover	ed under this plan.		
year of their 26th birthda upon you for a majority o disability or physical han considered as a basis for Your children beyond the year of their 26th birthda support. Your sponsored depende the internal Revenue Cod	end of the calendar year of their 26th y and continuoualy thereaffser) who a f their support and who are incapable dicap. (Under no circumstance will m continued coverage.) Please contact end of the calendar year of their 26th y and continuously thereafter) who a ints who are members of your family, is, were declared as dependents on y it tax year. (Children who are no longe	re developmentally disabled or physi e of self-sustaining employment by ental illness be considered a cause it NESSA to obtain the appropriate i n birthday (if covered under this pro- re full-time students and dependent either by blood or marriage, who qu our federal tax return for the preced	ically handicapped, dependent reason of their developmental of incapacity nor will it be form to continue coverage. gram at the end of the calendar to nyou for a majority of their valify as your dependents under ling tax year and are continuing in	

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question "What PAK/Bundle of Coverage do you want?"
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click **"Continue"** on the right-hand side of the screen.

		Your Info
*What PAK of Coverage do you want?	- Y	
PAK A		Employee Information
Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx		Family Info
Dental - Dent 80/80/80/80/1300(1500) Vision - VSP 2S	1	Questions
Negotiated LTD	T T	questions
PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D	2	Your Benefits
Basic Term Life - \$5,000	3	Enroll
PAK B	I I	
Dental - Dent 80/80/80/80:1300(1500) Vision - VSP 2S	(4)	Complete
Negotiated LTD		Constitute
PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D		Continue
PAK C		
Medical – MESSA ABC Plan 2		
Dental - Dent 80/80/80/80:1300(1500) Vision - VSP 2S		
Negotiated LTD		
PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D		
Basic Term Life - \$5,000		
PAK D		
Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx Dental - Dent 80/80/80/80:1300(1500)		
Vision – VSP 2S		
Negotiated LTD PAK Life - \$50,000 PAK Life		
PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5.000		
I want PAK A		
O I want PAK B		
O I want PAK C O I want PAK D		
* Fields are required		

• Click on "View Plan Options" to the right of each plan name.

•	Medical			٢	\$35.00 💌
	PLAN	MESSA ABC Plan 1 w/10% (View plan details	coinsurance, ABC Rx	/ Blue Cross Blue Shield	of Michigan /
	COVERAGE	Employee + Family			
		Gabriel Test	Employee	Cover	
		Paige Test	Spouse	Cover	
		Jason Test	Son	Cover	
	Completed				View Plan Options

• Uncheck the dependent's name and click "Continue".

Who will be cove	ered by this plan?			
Susan Test Employee	Spouse Test Child Test Spouse Daughter	Mark Tester Legal Guardianship	Add Dependents	
Back to Benefits				Continue

• Select the benefit plan by clicking "Select" or "Keep Selection".

CURRENT PLAN	
MESSA ABC Plan 1 w/10% coinsurance, ABC Rx	Your Cost per month:
Blue Cross Blue Shield of Michigan 🔞 High Deductible	\$25.00 💌 Tier: Employee + Dependent
Selected	
View plan details	Keep Selection
Plan Brochure	

• When finished going through every benefit plan, click "**Continue**" on the right-hand side.

•	Your Info		
2	Your Benefits		
3	Enroll		
4	Complete		
	ur Cost month	\$50.00	
Finished selecting benefits? Click the button below to continue.			
	Conti	nue	
Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.			
	Save and Fi	nish Later	

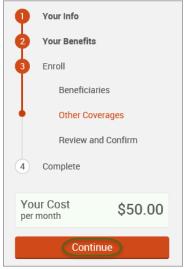
- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also "Add New Beneficiary" if you'd like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click "Continue."

		P Your Info
	ete and accurate before proceeding. ignated in writing and in accordance with the terms of the plan to receive any . "Secondary beneficiary" represents the person or persons named to receive	2 Your Benefits 3 Enroll Beneficiaries
		Other Coverages
Basic Term Life		Review and Confirm
Please choose your beneficiar	es	(4) Complete
Primary Beneficiaries (required)		Your Cost \$50.00
Name	Percentage	
My Estate (Employee)	%	Continue
Sally Test (Spouse)	100 %	
Johnny Test (Son)	%	
 ► Add New Beneficiary ► Add Secondary Beneficiaries (option Secondary beneficiaries receive money if your provide the secondary beneficiaries receive money if your		

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click "Yes" next to "Current or Prior Coverages" and enter the following information.
- Once you have entered the information, click "Save."

Medical	
John Test (Employee) Other Medical Insurance Coverage	a.
Current or Prior Coverages Other Insurance	● Yes ○ No New ➤
Policyholder Name	
Policy Number	
Policyholder's Employer	
Policyholder's Employer Address	
Policyholder's Employer Phone	555-555-5555
Insurance Carrier's Name	
Insurance Carrier's Phone	555-555-5555
Coverage Start Date	mm/dd/yyyy
Coverage End Date	mm/dd/yyyy
State/Country of Coverage	~
Coverage Level	Employee 🗸
Additional Info	
Save	

• If you do not have other medical coverage, keep "Current or Prior Coverages" as "No" and click "Continue".

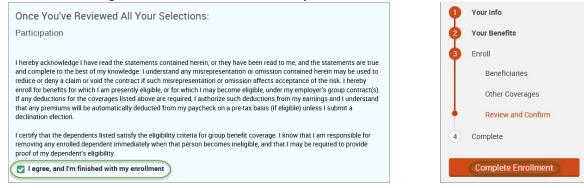


• Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

					1 Your Info
Please Review	v All of Your S	Selections			2 Your Benefits
					3 Enroll
nce you have completed y	our review, click the	"Complete Enrollment" k	outton at right si	de of the page	Beneficiaries
idicates changed benefits				Å0.00	Other Coverages
		Your	Total Cost	\$0.00 Per Month	Review and Confirm
Medical			Your cost per n	nonth \$0.00	4 Complete
A This benefit election	n is pending until approve	d by your Benefits Administrate	or		Complete Enrollment
MESSA ABC Plan	1 Blue Cross Blue Shield of	Michigan	COST DETAIL	S PER MONTH	
Who will be covered on t	his plan:		Your Cost	\$0.00	
Name	Relationship	Coverage 🚯			
Test User	Employee	Cover			
		Cover			

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."



A Confirmation Statement is presented and you may view, email or print the statement for your records.

		1
•	Your enrollment is complete! You may make changes to your elections until: September 1, 2017	
	Please view your enrollment confirmation statement and verify that your selections are correct.	
	Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Er would like to make changes to your enrollment selection, click the "Edit Selection" button located under ea	
	Your Confirmation Statement is ready Your Confirmation Statement is an overview of your new benefits and costs for your review and records.	VIEW MAIL PRINT

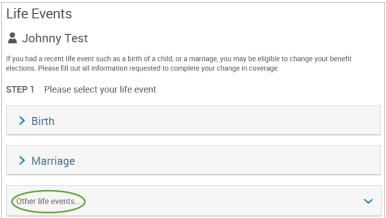
REMINDER: All benefit elections must be accepted by your Benefits Administrator.

Removing a Dependent from PARTIAL Benefits

• Hover your cursor over the "My Benefits" tab at the top of the screen and choose "Life Events."



• Select "Other life events..."



• Select "Family Status Change - Other."

Life Event

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth	
> Marriage	
Other life events	~
Divorce Legal Guardianship	
Child Becomes Eligible Child No Longer Eligible	
Family Status Change - Other	

• Enter the effective date (enter the last day of the month in which coverage is ending).

SIEP 2 Enter your life event information	
Family Status Change - Other	Change life event
When did your life event take place?	

Check the "I verify that all of the above Life Event information is correct." box.

Click "Save and Start Life Event Enrollment."	
STEP 3 Confirm your information	
Family Status Change - Other	Change life event
Life Event: Family Status Change - Other Date of Event: 11/01/2016	
I verify that all of the above Life Event information is correct.	
Hide Event from Employee	
Save and Start Life Event Enrollment Cancel	

- You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.
- Click "OK."

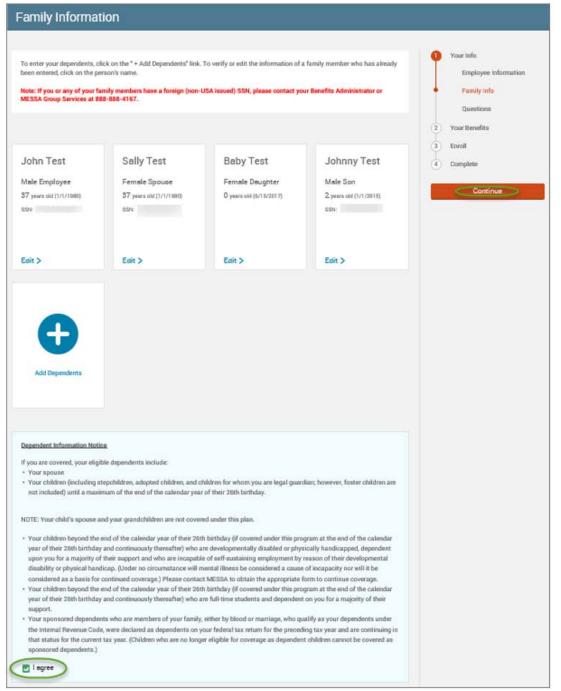
 In order to complete your life event, you must enroll or remove dependent(s) in your benefits. Please note that you have 30 days to complete your enrollment and that you may be required to supply additional documents to support your life event.

 OK

- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the "I agree" box.
- Click "Continue".

Employee Inform	nation	
	ment, all of your personal and family information must be complete. Please complete the required fields as already been entered, make sure it is accurate.	
Demographics		
* First Name	Test	
Middle Initial		
* Last Name	User	
Suffix		
Social Security Number		
* Date of Birth	1/1/1985	
* Gender	O Male	
* Fields are required Address		1 Your Info
Address 1		Employee Information
Address 2	1475 Kendale Blvd	Family Info
City	Fast Lanzing	Questions
U.S.	East Lansing	
State	MI - Michigan 👻	2 Your Benefits
Zip	48823	3 Enroll
Home Phone	XXX-XXX-XXXX	(4) Complete
Cell Phone	XXX-XXXX	Continue
Home Email		
WORK CONTACT INFORMA	TION	
Work Phone	XXX-XXXX	
Work Phone Ext.		
* Work Email	testuser@junkmail.com	
Preferred Email	Home Email O Work Email	
* Fields are required		
By checking the box "I Agree" b	below, you agree that the information above is accurate to the best of your knowledge.	

- Review/add/edit your Family Information.
- When finished with your Family Information, click the "I agree" box.
- Click "Continue".



NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question "What PAK/Bundle of Coverage do you want?"
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click **"Continue"** on the right-hand side of the screen.

*What PAK of Coverage do you want?	1 Your Info
PAK A Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx Dental - Dent 80/80/80/80:1300(1500) Vision - VSP 2S	Employee Information Family Info Questions
Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000	2 Your Benefits 3 Enroll
PAK B Dental - Dent 80/80/80/80:1300(1500) Vision - VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D	4 Complete
PAK C Medical – MESSA ABC Plan 2 Dental - Dent 80/80/80/80:1300(1500) Vision - VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000	
PAK D Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx Dental - Dent 80/80/80/80:1300(1500) Vision – VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000	
I want PAK A I want PAK B I want PAK C I want PAK D	
* Fields are required	

• Click on "View Plan Options" to the right of each plan name.

V	Medical				5.00 💌 t per month
	PLAN	MESSA ABC Plan 1 w/ View plan details	/10% coinsurance, ABC	$R \pmb{x}$ / Blue Cross Blue Shield of Michi	igan /
	COVERAGE	Employee + Family			
		Gabriel Test	Employee	Cover	
		Paige Test	Spouse	Cover	
		Jason Test	Son	Cover	
	Completed			View Plan	n Options

• Uncheck the dependent's name and click "Continue".

Who will be cove	red by this plan?			
Susan Test Employee	Spouse Test Child Test Spouse	Mark Tester Legal Guardianship	Add Dependents	
Seck to Benefits				Continue

• Select the benefit plan by clicking "Select" or "Keep Selection".

CURRENT PLAN	
MESSA ABC Plan 1 w/10% coinsurance, ABC Rx	Your Cost per month:
Blue Cross Blue Shield of Michigan 🛛 🙀 High Deductible	\$25.00 V Tier: Employee + Dependent
Selected	
View plan details	Keep Selection
Plan Brochure	

• When finished going through every benefit plan, click "**Continue**" on the right-hand side.

•	Your Info				
2	Your Benefits				
3	Enroll				
4	Complete				
	ur Cost month	\$50.00			
Finished selecting benefits? Click the button below to continue.					
	Conti	nue			
Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.					
	Save and Fi	nish Later			

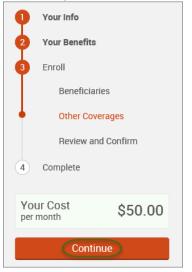
- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also "Add New Beneficiary" if you'd like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click "Continue."

Please verify your beneficiary information is complete and accurate before proceeding. "Beneficiary" represents the person or persons designated in writing and in accordance with the terms of the plan to receive any due beneficiary is deceased. Image: Basic Term Life Please choose your beneficiaries Primary Beneficiaries (required) Name Percentage My Estate (Employee) Sally Test (Spouse) Johnny Test (Son)	
due benefits after the death of an employee/retiree. "Secondary beneficiary" represents the person or persons named to receive benefits if the primary beneficiary is deceased. Basic Term Life Please choose your beneficiaries Primary Beneficiaries (required) Name Percentage My Estate (Employee) % Sally Test (Spouse) 100 %	
Basic Term Life Please choose your beneficiaries Primary Beneficiaries (required) Name Percentage My Estate (Employee) % Sally Test (Spouse) 100 %	
Basic Term Life Please choose your beneficiaries Primary Beneficiaries (required) Name Percentage My Estate (Employee) 100 % Continue	
Basic Term Life Please choose your beneficiaries Primary Beneficiaries (required) Name Percentage My Estate (Employee) \$ Sally Test (Spouse) 100 %	
Please choose your beneficiaries Primary Beneficiaries (required) Name Percentage My Estate (Employee) Sally Test (Spouse) 100 %	
Name Percentage My Estate (Employee) % Sally Test (Spouse) 100	
My Estate (Employee) % Sally Test (Spouse) 100	00
My Estate (Employee) % Sally Test (Spouse) 100 %	
Johnny Test (Son) %	
Total: 100%	
Add New Beneficiary	
✓ Add Secondary Beneficiaries (optional) Secondary beneficiaries receive money if your primary beneficiaries are unable to inherit.	

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click "Yes" next to "Current or Prior Coverages" and enter the following information.
- Once you have entered the information, click "Save."

Medical		
John Test (Employee) Other Medical Insurance Coverage	a.	
Current or Prior Coverages Other Insurance	● Yes ○ No New ➤	
Policyholder Name		
Policy Number		
Policyholder's Employer		
Policyholder's Employer Address		
Policyholder's Employer Phone	555-555-5555	
Insurance Carrier's Name		
Insurance Carrier's Phone	555-555-5555	
Coverage Start Date	mm/dd/yyyy	
Coverage End Date	mm/dd/yyyy	
State/Country of Coverage	~	
Coverage Level	Employee 🗸	
Additional Info		
Save		

• If you do not have other medical coverage, keep "Current or Prior Coverages" as "No" and click "Continue".

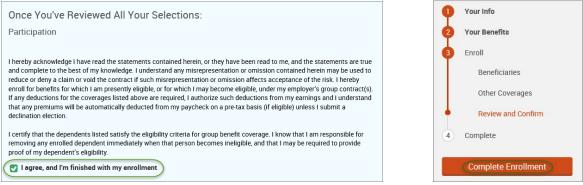


• Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

						P	Your Info
U	Please Review A	ll of Your S	elections			2	Your Benefits
Once yo	ou have completed your r	eview, click the	"Complete Enrollme	nt" button at right side	e of the page	3	Enroll Beneficiaries
*Indicates	s changed benefits		Y	′our Total Cost	\$0.00 Per Month		Other Coverages Review and Confirm
	Medical			Your cost per mo	nth \$0.00	4	Complete
	A This benefit election is pe	ending until approve	d by your Benefits Admini	strator			Complete Enrollment
	MESSA ABC Plan 1 в	ue Cross Blue Shield of	Michigan	COST DETAILS	PER MONTH		
	Who will be covered on this pl	an:		Your Cost	\$0.00		
	Name	Relationship	Coverage 🚯				
	Test User	Employee	Cover				
	Spouse User	Spouse	Cover				

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."



• A Confirmation Statement is presented and you may view, email or print the statement for your records.

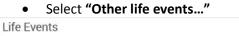
•	Your enrollment is complete! You may make changes to your elections until: September 1, 2017 Please view your enrollment confirmation statement and verify that your selections are correct. Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email would like to make changes to your enrollment selection, click the "Edit Selection" button located under each	
	Your Confirmation Statement is ready Your Confirmation Statement is an overview of your new benefits and costs for your review and records.	VIEW MAIL R PRINT

REMINDER: All benefit elections must be accepted by your Benefits Administrator.

Adding a Spouse

• Hover your cursor over the "My Benefits" tab at the top of the screen and choose "Life Events."

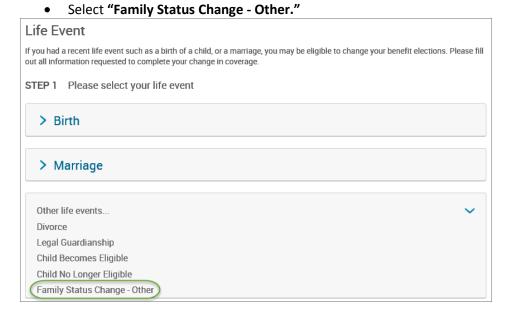




💄 Johnny Test

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

> Bi	irth	
> M	arriage	



• Enter the effective date (first day of the month).



- Check the "I verify that all of the above Life Event information is correct." box.
- Click "Save and Start Life Event Enrollment."

STEP 3 Confirm your information	
Family Status Change - Other	Change life event
Life Event: Family Status Change - Other Date of Event: 11/01/2016	
I verify that all of the above Life Event information is correct.	
Hide Event from Employee	
Cancel	

• You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.

• (Click "OK."	
<u>^</u>	In order to complete your life event, you must enroll or rem dependent(s) in your benefits. Please note that you have 30 complete your enrollment and that you may be required to additional documents to support your life event.	0 days to
	[ОК

- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the "I agree" box.
- Click "Continue".

Employee Inform	nation		
	Iment, all of your personal and family information must be complete. Please complete the required fields has already been entered, make sure it is accurate.		
Demographics			
* First Name	100		
Middle Initial * Last Name			
Suffix			
Social Security Number			
* Date of Birth	1/1/1985		
* Gender	O Male		
* Fields are required			
Address		0	Your Info
Address 1	1475 Kendale Blvd	+	Employee Information
Address 2			Family Info
City	East Lansing		Questions
State	MI - Michigan	2	Your Benefits
Zip	48823	3	Enroll
Home Phone	XXX-XXXX	4	Complete
Cell Phone	XXX-XXX-XXXX		Continue
Home Email		_	
WORK CONTACT INFORM	ATION		
Work Phone	XXX-XXX		
Work Phone Ext. * Work Email			
Preferred Email	estuser@junkmail.com Home Email O Work Email		
* Fields are required			
By checking the box "I Agree" I	below, you agree that the information above is accurate to the best of your knowledge.		

- Review/add/edit your Family Information.
- To add your spouse, click "Add Dependents" and complete the spouse's demographic information and click "Save & Continue".

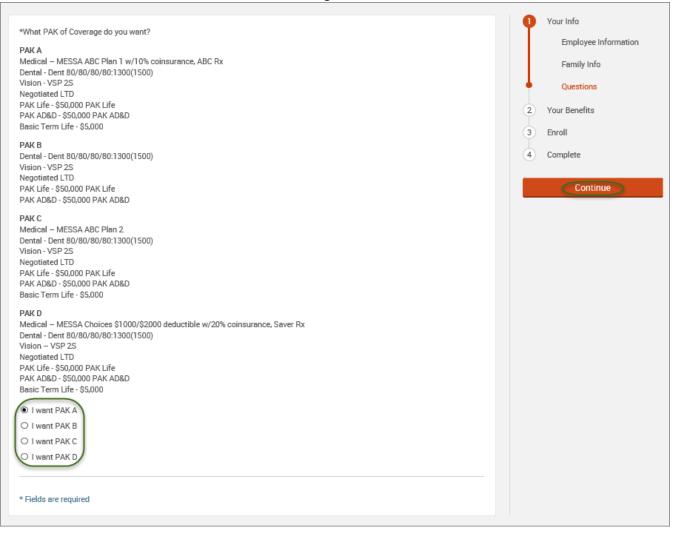
Ð			
Add Dependents			
Dependent Demographic			
(* First Name)			
Middle Initial			
* Last Name			
Suffix			
* Date of Birth (mm/dd/yyyy)			
* Social Security Number XXX-XX-XXXXX			
*Gender O Male O Female			
* Relationship			
* Fields are required			
	Cancel	🕂 Save & Add Another	Save & Continue

- When finished with your Family Information, click the "I agree" box.
- Click "Continue".

Family Informat	tion			
been entered, click on the pe	amily members have a foreign (non-U			Your Info Employee Information Family Info Questions Your Benefits
John Test Male Employee 37 years old (1/1/1080) 55%	Sally Test Female Spouce 37 years and (1/1/1980) 55%	Baby Test Female Daughter O years old (br1 5/2017)	Johnny Test Male Son 2 years old (1/1/2015) 55%	3 Entol 4 Domplete
Edit >	Edit >	Edit >	Edit >	
Add Dependents				
			dian; however, foster children are	
 Your children beyond the year of their 26th birthday upon you for a majority of disability or physical ham considered as a basis for Your children beyond the year of their 26th birthday support. Your aponsored dependen the internal Revenue Cod 	ind your grandchildren are not cover end of the calendar year of their 26th y and continuously thereafter) who a f their support and who are incapable dicap. (Under no circumstance will m continued coverage.) Please contact end of the calendar year of their 26th y and continuously thereafter) who a nts who are members of your family, e, were declared as dependents on y t tax year. (Children who are no longe	h birthday (if covered under this pro e of self-austaining employment by ental illness be considered a cause t MESSA to obtain the appropriate f h birthday (if covered under this pro re full-time students and dependent either by blood or marriage, who qu our federal tax return for the preced	ically handicapped, dependent reason of their developmental of incapacity nor will it be form to continue coverage. gram at the end of the calendar con you for a majority of their allify as your dependents under ing tax year and are continuing in	

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

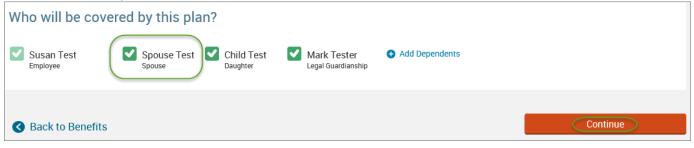
- You will be presented with the question "What PAK/Bundle of Coverage do you want?"
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click **"Continue"** on the right-hand side of the screen.



• Click on "View Plan Options" to the right of each plan name.

V	Medical				\$35.00 💌 Your Cost per month
	PLAN	MESSA ABC Plan 1 View plan details	w/10% coinsurance, ABC	CRX / Blue Cross Blue Shi	ield of Michigan /
	COVERAGE	Employee + Family			
		Gabriel Test	Employee	🕑 Cover	
		Paige Test	Spouse	Cover	
		Jason Test	Son	Cover	
	Completed			(View Plan Options

• Check the spouse's name and click "Continue".



• Select the benefit plan by clicking "Select" or "Keep Selection".

CURRENT PLAN	
MESSA ABC Plan 1 w/10% coinsurance, ABC Rx	Your Cost per month:
Blue Cross Blue Shield of Michigan 🔞 High Deductible	\$25.00 V Tier: Employee + Dependent
 Selected 	
View plan details	Keep Selection

• When finished going through every benefit plan, click "**Continue**" on the right-hand side.

Q	Your Info			
2	Your Benefits			
3	Enroll			
4	Complete			
	ur Cost month	\$50.00		
	hed selecting be n below to conti			
	Conti	nue		
Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.				
	Save and Fi	nish Later		

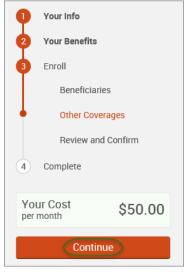
- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also "Add New Beneficiary" if you'd like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click "Continue."

		Your Info
Please verify your beneficiary information is compl "Beneficiary" represents the person or persons desi	2 Your Benefits	
due benefits after the death of an employee/retiree. benefits if the primary beneficiary is deceased.	"Secondary beneficiary" represents the person or persons named to receive	3 Enroll
Scheme in the primary Schemenary to accededed.		Beneficiaries
		Other Coverages
Basic Term Life		Review and Confirm
Please choose your beneficiari	es	4 Complete
Primary Beneficiaries (required)		Your Cost \$50.00
Name	Percentage	
My Estate (Employee)	%	Continue
Sally Test (Spouse)	100 %	
Johnny Test (Son)	%	
Total	100%	
Add New Beneficiary		
✓ Add Secondary Beneficiaries (option Secondary beneficiaries receive money if your preserved and the secondary beneficiaries receive money if your preserved and the secondary beneficiaries receive money if your preserved and the secondary beneficiaries receive money if your preserved and the secondary beneficiaries receive money if your preserved and the secondary beneficiaries received and the sec	,	

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click "Yes" next to "Current or Prior Coverages" and enter the following information.
- Once you have entered the information, click "Save."

Medical	
John Test (Employee) Other Medical Insurance Coverage	a- -
Current or Prior Coverages Other Insurance	● Yes ○ No New ~
Policyholder Name	
Policy Number	
Policyholder's Employer	
Policyholder's Employer Address	
Policyholder's Employer Phone	555-555-5555
Insurance Carrier's Name	
Insurance Carrier's Phone	555-555-5555
Coverage Start Date	mm/dd/yyyy
Coverage End Date	mm/dd/yyyy
State/Country of Coverage	~
Coverage Level	Employee
Additional Info	
Save	

• If you do not have other medical coverage, keep "Current or Prior Coverages" as "No" and click "Continue".

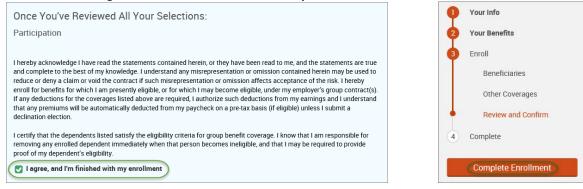


• Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

D	Please Revie	w All of Your S	Selections			2	Your Info Your Benefits
nce yo	ou have completed y	your review, click the	"Complete Enrollm	ent" button at right s	ide of the page	3	Enroll Beneficiaries
ndicate	s changed benefits			Your Total Cost	\$0.00 Per Month		Other Coverages Review and Confirm
\bullet	Medical			Your cost per	month \$0.00	4	Complete
	A This benefit election	on is pending until approve	d by your Benefits Admi	nistrator			Complete Enrollment
	MESSA ABC Pla	${\sf n}$ 1 Blue Cross Blue Shield of	Michigan	COST DETAI	LS PER MONTH		
	Who will be covered on			Your Cost	\$0.00		
	Name Test User	Relationship Employee	Coverage 🕄				
	Spouse User	Spouse	Cover				

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."



• A Confirmation Statement is presented and you may view, email or print the statement for your records.

•	Your enrollment is complete!					
	Please view your enrollment confirmation statement and verify that your selections are correct.					
	Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email" to email yourself a copy of the statement. If you would like to make changes to your enrollment selection, click the "Edit Selection" button located under each plan.					
	Your Confirmation Statement is ready Your Confirmation Statement is an overview of your new benefits and costs for your review and records.	VIEW MAIL PRINT				

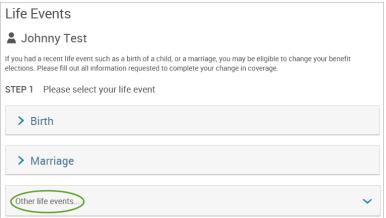
REMINDER: All benefit elections must be accepted by your Benefits Administrator.

Removing a Spouse

• Hover your cursor over the "My Benefits" tab at the top of the screen and choose "Life Events."



• Select "Other life events..."



• Select "Family Status Change - Other."

Life Event

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event	
> Birth	
> Marriage	
Other life events	\sim
Divorce	
Legal Guardianship	
Child Becomes Eligible	
Child No Longer Eligible	
Family Status Change - Other	

• Enter the effective date (enter the last day of the month in which coverage is ending).

STEP 2 Enter your life event information	
Family Status Change - Other	Change life event
When did your life event take place?	
Enter a date (mm/dd/yyyy)	

- Check the "I verify that all of the above Life Event information is correct." box.
- Click "Save and Start Life Event Enrollment."

STEP 3 Confirm your information	
Family Status Change - Other	Change life event
Life Event: Family Status Change - Other Date of Event: 11/01/2016	
I verify that all of the above Life Event information is correct.	
Hide Event from Employee	
Save and Start Life Event Enrollment Cancel	

• You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.

•	Click "OK."
<u>^</u>	In order to complete your life event, you must enroll or remove dependent(s) in your benefits. Please note that you have 30 days to complete your enrollment and that you may be required to supply additional documents to support your life event.
	ОК

- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the "I agree" box.
- Click "Continue".

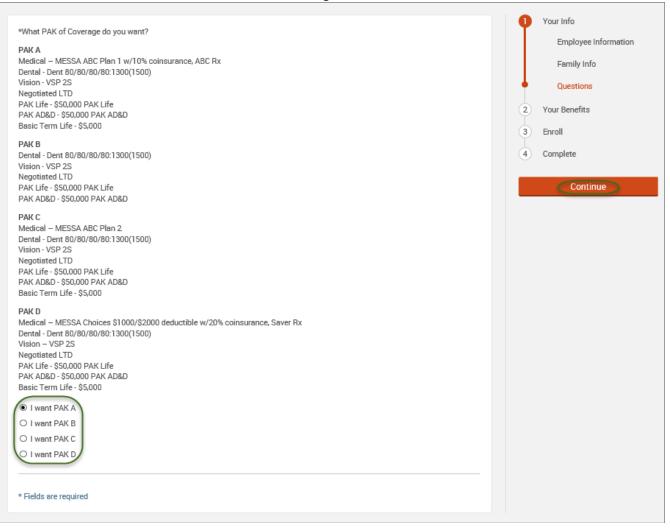
Employee Inform	nation		
		-	
	ment, all of your personal and family information must be complete. Please complete the required fields as already been entered, make sure it is accurate.		
Demographics			
* First Name Middle Initial	1.00		
*Last Name			
Suffix Social Security Number			
* Date of Birth	1/1/1985		
* Gender	O Male		
* Fields are required			
Address		•	Your Info
Address 1	1475 Kendale Blvd	•	Employee Information
Address 2			Family Info
City	East Lansing		Questions
State	MI - Michigan	2	Your Benefits
Zip	48823	3	Enroll
Home Phone	XXX-XXX-XXXX	4	Complete
Cell Phone	XXX-XXX-XXXX		Continue
Home Email			
WORK CONTACT INFORM	λτιον		
Work Phone	XXX-XXX-XXXX		
Work Phone Ext.			
* Work Email	testuser@junkmail.com		
Preferred Email	Home Email O Work Email		
* Fields are required			
By checking the box "I Agree" I	pelow, you agree that the information above is accurate to the best of your knowledge.		

- Review/add/edit your Family Information.
- When finished with your Family Information, click the "I agree" box.
- Click "Continue".

	infy or edit the information of a fan swed) SSN, please contact your B Baby Test Female Daughter O years old (6/1 5/2017) Edit >		234	Your Info Employee Information Family Info Questions Your Benefits Enroll Complete
Spouee	Fernalle Daughter O years old (6/1 5/2017)	Male Son 2 years old (1/1/2015) 55%	3	Enroll Complete
	Edit >	Edit >		
nclude: oted children, and children of the calendar year of the	n for whom you are legal guardian; sir 26th birthday.	; however, foster children are		
ildren are not covered und	Ser this plan.			
ly thereafter) who are deve id who are incapable of set circumstance will mental i age.) Please contact MESI dar year of their 26th birth hy thereafter) who are full-	elopmentally disabled or physical lef-sustaining employment by reas illness be considered a cause of i illows be considered a cause of i illows be considered a cause of illows and the appropriate form day (if covered under this program day (if covered under this program time students and dependent on the blood or marriage, who qualify deral tax return for the preceding to	by handicapped, dependent son of their developmental incapacity nor will it be to continue coverage. In at the end of the calendar you for a majority of their y as your dependents under tax year and are continuing in		
	dar year of their 26th birth hy thereafter) who are dev d who are incapable of is circumstance will mental age.) Please contact MES dar year of their 26th birth hy thereafter) who are full theres of your family, either as dependents on your fe	hy thereafter) who are developmentally disabled or physical d who are incapable of self-sustaining employment by rear circumstance will mental illness be considered a cause of i age, Please contact MESSA to obtain the appropriate form dar year of their 26th birthday (if covered under this progras by thereafter) who are full-time students and dependent on there of your family, either by blood or marriage, who qualifi as dependents on your federal tax return for the preceding	ildren are not covered under this plan. dar year of their 26th birthday (if covered under this program at the end of the calendar hy thereaffser) who are developmentally disabled or physically handicapped, dependent ad who are incapable of self-sustaining employment by reason of their developmental circumstance will mental likes be considered a cause of incapacity nor will it be age.) Please contact MESSA to obtain the appropriate form to courtinue coverage. dar year of their 26th birthday (if covered under this program at the end of the calendar hy thereafter) who are full-time students and dependent on you for a majority of their obses of your family, either by blood or marriage, who qualify as your dependents under an dependents on your federal tax return for the preceding tax year and are continuing in ren who are no longer eligible for coverage as dependent children cannot be covered as	dar year of their 28th birthday (if covered under this program at the end of the calendar thy thereafter) who are developmentally disabled or physically handicapped, dependent at who are incapable of self-sustaining employment by reason of their developmental circumstance will mental illness be considered a cause of incapacity nor will it be age.) Please contact MESSA to obtain the appropriate form to continue coverage. dar year of their 28th birthday (if covered under this program at the end of the calendar by thereafter) who are full-time students and dependent on you for a majority of their others of your family, either by blood or marriage, who qualify as your dependents under as dependents on your federal tax return for the preceding tax year and are continuing in

OTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question "What PAK/Bundle of Coverage do you want?"
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click **"Continue"** on the right-hand side of the screen.



• Click on "View Plan Options" to the right of each plan name.

•	Medical				\$35.00 💌 Your Cost per month
	PLAN	MESSA ABC Plan 1 View plan details	w/10% coinsurance, ABC	Rx / Blue Cross Blue Shi	eld of Michigan /
	COVERAGE	Employee + Family			
		Gabriel Test	Employee	Cover	
		Paige Test	Spouse	Cover	
		Jason Test	Son	Cover	
	Completed			(View Plan Options

• Uncheck the spouse's name and click "Continue".

Who will be covered by this plan?	
Susan Test Employee Spouse Test Spouse Child Test Daughter Add Dependents	
Seck to Benefits	Continue

• Select the benefit plan by clicking "Select" or "Keep Selection".

CURRENT PLAN	
MESSA ABC Plan 1 w/10% coinsurance, ABC Rx	Your Cost per month:
Blue Cross Blue Shield of Michigan 🗧 High Deductible	\$25.00 V Tier: Employee + Dependent
Selected	
View plan details	Keep Selection
🧏 Plan Brochure	

• When finished going through every benefit plan, click "**Continue**" on the right-hand side.

•	Your Info	
2	Your Benefi	its
3	Enroll	
4	Complete	
	ur Cost month	\$50.00
	ned selecting n below to co	benefits? Click the ontinue.
	Cor	ntinue
enroll the bu	ment? No pro	lete your benefits oblem, you can click o save your progress
Save and Finish Later		
	Save and	Finish Later

- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also "Add New Beneficiary" if you'd like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click "Continue."

		P Your Info
	blete and accurate before proceeding. signated in writing and in accordance with the terms of the plan to receive any e. "Secondary beneficiary" represents the person or persons named to receive	2 Your Benefits 3 Enroll Beneficiaries
		Other Coverages
Basic Term Life		Review and Confirm 4. Complete
Please choose your beneficia	ries	4 Complete
Primary Beneficiaries (required)		Your Cost \$50.00
Name	Percentage	
My Estate (Employee)	%	Continue
Sally Test (Spouse)	100 %	
Johnny Test (Son)	%	
 ◆ Add New Beneficiary ◆ Add Secondary Beneficiaries (opi Secondary beneficiaries receive money if your 		

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click "Yes" next to "Current or Prior Coverages" and enter the following information.
- Once you have entered the information, click "Save."

Medical		
John Test (Employee) Other Medical Insurance Coverag	e:	
Current or Prior Coverages Other Insurance	● Yes ○ No New ✔	
Policyholder Name		
Policy Number		
Policyholder's Employer		
Policyholder's Employer Address		
Policyholder's Employer Phone	555-555-5555	
Insurance Carrier's Name		
Insurance Carrier's Phone	555-555-5555	
Coverage Start Date	mm/dd/yyyy	
Coverage End Date	mm/dd/yyyy	
State/Country of Coverage		~
Coverage Level	Employee	~
Additional Info		
Save		

• If you do not have other medical coverage, keep "Current or Prior Coverages" as "No" and click "Continue".

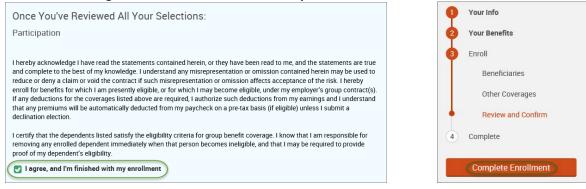
Your Info		
2 Your Benefits		
3 Enroll		
Beneficiarie	es	
• Other Coverages		
Review and Confirm		
4 Complete		
Your Cost \$50.00		
Continue		

• Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

•					Your Info
Please Review A	Please Review All of Your Selections				2 Your Benefits
Once you have completed your review, click the "Complete Enrollment" button at right side of the page				3 Enroll	
nee you have completed your r	eview, eller the		r button at right sid	le of the page	Beneficiaries
Indicates changed benefits				\$0.00	Other Coverages
		Yo	ur Total Cost	Per Month	Review and Confirm
• Medical			Your cost per me	onth \$0.00	4 Complete
A This benefit election is pe	nding until approve	d by your Benefits Administ	rator		Complete Enrollment
MESSA ABC Plan 1 BI	ue Cross Blue Shield of	Michigan	COST DETAILS	PER MONTH	
Who will be covered on this pla	an:		Your Cost	\$0.00	
Name	Relationship	Coverage 🕄			
Test User	Employee	Over			
Spouse User	Spouse	Cover			

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."



• A Confirmation Statement is presented and you may view, email or print the statement for your records.

•	Your enrollment is complete! You may make changes to your elections until: September 1, 2017 Please view your enrollment confirmation statement and verify that your selections are correct. Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Err would like to make changes to your enrollment selection, click the "Edit Selection" button located under each	
	Your Confirmation Statement is ready Your Confirmation Statement is an overview of your new benefits and costs for your review and records.	🖻 VIEW 🗹 EMAIL 😭 PRINT

REMINDER: All benefit elections must be accepted by your Benefits Administrator.

Adding Medical

• Hover your cursor over the "My Benefits" tab at the top of the screen and choose "Life Events."



• Select "Other life events..."

Life Events
🛓 Johnny Test
If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.
STEP 1 Please select your life event
> Birth
> Marriage
Other life events

• Select "Family Status Change - Other."

Life Event

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth	
> Marriage	
Other life events	~
Divorce	
Legal Guardianship	
Child Becomes Eligible	
Child No Longer Eligible	
Family Status Change - Other	

• Enter the effective date (first of the month).

STEP 2 Enter your life event information	
Family Status Change - Other	Change life event
When did your life event take place?	
Enter a date) (mm/dd/yyyy)	

- Check the "I verify that all of the above Life Event information is correct." box.
- Click "Save and Start Life Event Enrollment."

STEP 3 Confirm your information	
Family Status Change - Other	Change life event
Life Event: Family Status Change - Other Date of Event: 11/01/2016	
I verify that all of the above Life Event information is correct.	
Hide Event from Employee	
Cancel	

• You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.

•	Click " OK. "
<u>^</u>	In order to complete your life event, you must enroll or remove dependent(s) in your benefits. Please note that you have 30 days to complete your enrollment and that you may be required to supply additional documents to support your life event.
	ОК

- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the "I agree" box.
- Click "Continue".

Employee Inform	nation		
	ment, all of your personal and family information must be complete. Please complete the required fields as already been entered, make sure it is accurate.		
Demographics			
* First Name	Test		
Middle Initial			
* Last Name	User		
Suffix			
Social Security Number			
Date of birth	1/1/1985		
* Gender	O Male		
* Fields are required			
Address		•	Your Info
Address 1	1475 Kendale Blvd	•	Employee Information
Address 2			Family Info
City	East Lansing		Questions
State		2	Your Benefits
	MI - Michigan	3	Enroll
Zip Home Phone	48823	4	Complete
Cell Phone	XXX-XXX-XXXX		
Home Email	XXX-XXX-XXXX		Continue
WORK CONTACT INFORM			
Work Phone	XXX-XXX		
Work Phone Ext. * Work Email			
Preferred Email	testuser@junkmail.com ● Home Email ○ Work Email		
Preferreu Email			
* Fields are required			
By checking the box "I Agree" I	below, you agree that the information above is accurate to the best of your knowledge.		

- Review/add/edit your Family Information.
- When finished with your Family Information, click the "I agree" box.
- Click "Continue".

Family Informati	on			
been entered, click on the per-	son's name. Ny members have a foreign (non-U	Fo verify or edit the information of a ISA issued) SSN, please contact you		Your Info Employee Information Family Info Questions
John Test Male Employee 37 years old (1/1/1080) 5594	Sally Test Female Spouce 37 years and (1/1/1986) save	Baby Test Female Daughter O years old (6/15/2017)	Johnny Test Male Son 2 years old (1/1/2015) 55N	Continue
Edit >	Edit >	Edit >	Edit >	
Add Dependents				
A STALLARD TO STALLARD STALLARD STALLARD	le dependents include:	ildren for whom you are legal guard of their 26th birthday.	lian; however, foster children are	
 Your children beyond the ei year of their 26th birthday a upon you for a majority of t disability or physical handi considered as a basis for co Your children beyond the ei year of their 26th birthday a support. Your sponsored dependent the internal Revenue Code, 	and continuously thereafter) who are heir support and who are incapable cap. (Under no circumstance will m ontinued coverage.) Please contact nd of the calendar year of their 26th and continuously thereafter) who ar s who are members of your family, were declared as dependents on yo	d under this plan. birthday (if covered under this pro- e developmentally disabled or phys- of self-sustaining employment by i ental liness be considered a cause MESSA to obtain the appropriate § birthday (if covered under this pro- e full-time students and dependent either by blood or marriage, who qui sur federal tax return for the preceding r eligible for coverage as dependent	ically handicapped, dependent reason of their developmental of incapacity nor will it be orm to continue coverage. gram at the end of the calendar on you for a majority of their alify as your dependents under ing tax year and are continuing in	

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question "What PAK/Bundle of Coverage do you want?"
- Review the benefits in each PAK/Bundle that have medical and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click **"Continue"** on the right-hand side of the screen.

	1 Your Info
*What PAK of Coverage do you want?	Employee Information
PAK A Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx Dental - Dent 80/80/80:1300(1500) Vision - VSP 2S	Family Info Questions
Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000	2 Your Benefits 3 Enroll
PAK B Dental - Dent 80/80/80:1300(1500) Vision - VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D	4 Complete
PAK C Medical – MESSA ABC Plan 2 Dental - Dent 80/80/80/1300(1500) Vision - VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000	
PAK D Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx Dental - Dent 80/80/80/300(1500) Vision – VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000	
I want PAK A I want PAK B I want PAK C I want PAK D	
* Fields are required	

• Click on "View Plan Options" to the right of the medical plan name.

Medical				\$0.00 Vour Cost per month
PLAN	Waive Medical Coverage	e / WAIVE MEDICAL		
COVERAGE				
	Daniel Test	Employee	Cover	
	Susan Test	Spouse	😣 No Coverage	
	John Test	Son	😣 No Coverage	
* Selection Requ	ired		Keep My Selection	View Plan Options

- To cover a dependent, check the box next to their name.
- To remove a dependent, uncheck the box next to their name.
- Click "Continue".



• Select the medical plan by clicking "Select".

MESSA ABC Plan 1 Blue Cross Blue Shield of Michigan	Your Cost per month: \$50.00	
View plan details Plan Brochure	Tier: Employee + Family	
	Sciect	

• When finished going through every benefit plan, click "**Continue**" on the right-hand side.

Q	Your Info			
2	Your Benefits			
3	Enroll			
4	Complete			
	ur Cost month	\$50.00		
	hed selecting be on below to cont	enefits? Click the inue.		
	Conti	nue		
Not ready to complete your benefits enrollment? No problem, you can click the button below to save your progress and return later.				

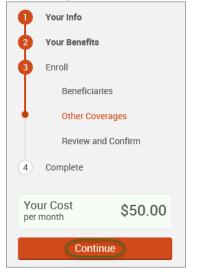
- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also "Add New Beneficiary" if you'd like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click "Continue."

		Your Info
Please verify your beneficiary information is co	2 Your Benefits	
	designated in writing and in accordance with the terms of the plan to receive any iree. "Secondary beneficiary" represents the person or persons named to receive	3 Enroll
		Beneficiaries
		Other Coverages
Basic Term Life		Review and Confirm
Please choose your benefic	aries	(4) Complete
Primary Beneficiaries (required)		Your Cost \$50.00
Name	Percentage	
My Estate (Employee)	%	Continue
Sally Test (Spouse)	100 %	
Johnny Test (Son)	%	
Тс	tal: 100%	
• Add New Beneficiary		
✓ Add Secondary Beneficiaries (Secondary beneficiaries receive money if yo	pptional) ur primary beneficiaries are unable to inherit.	
Secondary beneficiaries receive money if yo	ur primary beneficiaries are unable to inherit.	

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click "Yes" next to "Current or Prior Coverages" and enter the following information.
- Once you have entered the information, click "Save."

Medical	
John Test (Employee) Other Medical Insurance Coverage	3-
Current or Prior Coverages Other Insurance	● Yes ○ No New ~
Policyholder Name	
Policy Number	
Policyholder's Employer	
Policyholder's Employer Address	
Policyholder's Employer Phone	555-555-5555
Insurance Carrier's Name	
Insurance Carrier's Phone	555-555-5555
Coverage Start Date	mm/dd/yyyy
Coverage End Date	mm/dd/yyyy
State/Country of Coverage	~
Coverage Level	Employee 🗸
Additional Info	
Save	

• If you do not have other medical coverage, keep "Current or Prior Coverages" as "No" and click "Continue".

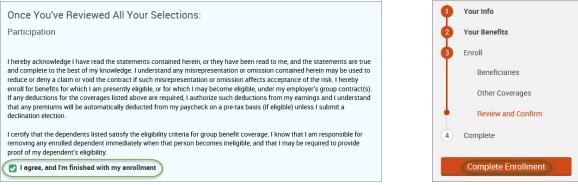


• Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

						•	Your Info
	Please Review	w All of Your S	Selections			Q	Your Benefits
						3	Enroll
nce yo	ou have completed y	our review, click the	"Complete Enrollmen	t" button at right s	ide of the page		Beneficiaries
dicates	s changed benefits				Å0.00		Other Coverages
			Yo	ur Total Cost	\$0.00 Per Month	•	Review and Confirm
	Medical			Your cost per	month \$0.00	4	Complete
	A This benefit election	on is pending until approve	d by your Benefits Administ	rator			Complete Enrollment
	MESSA ABC Pla	1 Blue Cross Blue Shield of	Michigan	COST DETA	ILS PER MONTH		
	Who will be covered on	this plan:		Your Cos	t \$0.00		
	Name	Relationship	Coverage 🚯				
	Test User	Employee	Over				
	Spouse User	Spouse	Cover				

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."



• A Confirmation Statement is presented and you may view, email or print the statement for your records.

⊘	Your enrollment is complete! You may make changes to your elections until: September 1, 2017 Please view your enrollment confirmation statement and verify that your selections are correct. Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email" would like to make changes to your enrollment selection, click the "Edit Selection" button located under each p	
	Your Confirmation Statement is ready Your Confirmation Statement is an overview of your new benefits and costs for your review and records.	VIEW MAIL PRINT

REMINDER: All benefit elections must be accepted by your Benefits Administrator.

Removing Medical

• Hover your cursor over the "My Benefits" tab at the top of the screen and choose "Life Events."



• Select "Other life events..."

Life Events

💄 Johnny Test

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

Birth

> Marriage

Other life events...

• Select "Family Status Change - Other."

Life Event

If you had a recent life event such as a birth of a child, or a marriage, you may be eligible to change your benefit elections. Please fill out all information requested to complete your change in coverage.

STEP 1 Please select your life event

> Birth	
> Marriage	
Other life events	~
Divorce	
Legal Guardianship	
Child Becomes Eligible	
Child No Longer Eligible	
Family Status Change - Other	

• Enter the effective date (last day of the month in which coverage is ending).

STEP 2 Enter your life event information	
Family Status Change - Other	Change life event
When did your life event take place?	
Enter a date (mm/dd/yyyy)	

- Check the "I verify that all of the above Life Event information is correct." box.
- Click "Save and Start Life Event Enrollment."

STEP 3 Confirm your information	
Family Status Change - Other	Change life event
Life Event: Family Status Change - Other Date of Event: 11/01/2016	
I verify that all of the above Life Event information is correct.	
Hide Event from Employee	
Save and Start Life Event Enrollment Cancel	

- You will receive a pop-up that informs you that in order to complete this life event, you must enroll/remove the dependent in benefits.
- Click "OK."

4	In order to complete your life event, you must enroll or remove dependent(s) in your benefits. Please note that you have 30 days to complete your enrollment and that you may be required to supply additional documents to support your life event.	
	ОК	

- Review your Employee (personal) Information and make any necessary updates.
- When finished with your Employee Information, click the "I agree" box.
- Click "Continue".

Employee Inform	nation	
	ment, all of your personal and family information must be complete. Please complete the required fields as already been entered, make sure it is accurate.	
Demographics		
* First Name Middle Initial	1531	
* Last Name Suffix	(de)	
Social Security Number	1/1/1985	
* Gender	O Male	
* Fields are required		
Address		1 Your Info
Address 1	1475 Kendale Blvd	Employee Information
Address 2		Family Info
City	East Lansing	Questions
State	MI - Michigan	2 Your Benefits
Zip	48823	3 Enroll
Home Phone	XXX-XXX-XXXX	4 Complete
Cell Phone	XXX-XXX	Continue
Home Email		
WORK CONTACT INFORM	ATION	
Work Phone	XXX-XXX-XXXX	
Work Phone Ext.		
* Work Email	testuser@junkmail.com	
Preferred Email		
* Fields are required		
By checking the box "I Agree" t	below, you agree that the information above is accurate to the best of your knowledge.	

- Review/add/edit your Family Information.
- When finished with your Family Information, click the "I agree" box.
- Click "Continue".

Family Information	n			
been entered, click on the perso	on's name. Iy members have a foreign (non-U	o verify or edit the information of a SA insued) SSN, please contact you		Your Info Employee Information Family Info Questions
John Test Male Employee 37 years old (1/1/1080) 5574	Sally Test Female Spouce 37 years and (1/1/1980) SSN:	Baby Test Female Daughter O years eld (6/15/2017)	Johnny Test Male Son 2 years old (1/1/2015) SSN:	Your Benefits Second
Edit >	Edit >	Edit >	Edit >	
Add Dependents				
		ldren for whom you are legal guard If their 26th birthday.	an; however, foster children are	
 Your children beyond the encyear of their 26th birthday ar upon you for a majority of th disability or physical handics considered as a basis for cor Your children beyond the ency year of their 26th birthday ar support. Your sponsored dependents the internal Revenue Code, w 	Ind continuously thereafter) who are eir support and who are incapable ap. (Under no circumstance will me ntinued coverage.) Please contact d of the calendar year of their 26th ad continuously thereafter) who are who are members of your family, e vere declared as dependents on yo	d under this plan. birthday (if covered under this prog e developmentally disabled or physi of self-sustaining employment by re- ntal illness be considered a cause o MESSA to obtain the appropriate fo birthday (if covered under this prog e full-time students and dependent of ither by blood or marriage, who qua ur federal tax return for the precedit eligible for coverage as dependent	cally handicapped, dependent sason of their developmental of incapacity nor will it be rm to continue coverage. ram at the end of the calendar on you for a majority of their lify as your dependents under ng tax year and are continuing in	

NOTE: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

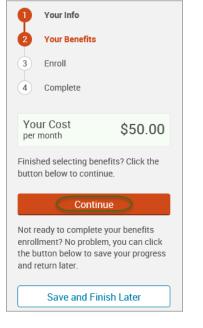
- You will be presented with the question "What PAK/Bundle of Coverage do you want?"
- Select the PAK/Bundle that does not have medical and click "Continue" on the right-hand side of the screen.

*What PAK of Coverage do you want? PAK A Medical – MESSA ABC Plan 1 w/10% coinsurance, ABC Rx Dental - Dent 80/80/80/80:1300(1500) Vision - VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D	2	Four info Employee Information Family Info Questions Your Benefits
Basic Term Life - \$5,000 PAK B Dental - Dent 80/80/80/80:1300(1500) Vision - VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life	3	Enroll Complete Continue
PAK AD&D - \$50,000 PAK AD&D PAK C Medical – MESSA ABC Plan 2 Dental - Dent 80/80/80/80:1300(1500) Vision - VSP 2S Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000		
PAK D Medical – MESSA Choices \$1000/\$2000 deductible w/20% coinsurance, Saver Rx Dental - Dent 80/80/80/80:1300(1500) Vision – VSP 2LS Negotiated LTD PAK Life - \$50,000 PAK Life PAK AD&D - \$50,000 PAK AD&D Basic Term Life - \$5,000		
 I want PAK A I want PAK B I want PAK C I want PAK D 		
* Fields are required		

• Click on "I don't want this benefit (waive)" under the medical plan name.

•	Medical				\$50.00 💟 Your Cost per month
		MESSA ABC Plan 1 Employee + Family	/ Blue Cross Blue Shield of	Michigan / View plan de	tails
		Daniel Test Susan Test John Test	Employee Spouse Son	CoverCoverCover	
	Completed		Ido	n't want this benefit (waive)	View Plan Options

• When finished going through every benefit plan, click "**Continue**" on the right-hand side.



- You will be required to designate at least one primary beneficiary information when you have life insurance.
- Dependents will automatically appear for you to designate, however you may also "Add New Beneficiary" if you'd like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click "Continue."

		1 Your Info					
Please verify your beneficiary information is compl "Beneficiary" represents the person or persons desi	2 Your Benefits						
	"Secondary beneficiary" represents the person or persons named to receive	3 Enroll					
benefits in the primary beneficiary is deceased.		Beneficiaries					
		Other Coverages					
Basic Term Life		Review and Confirm					
		4 Complete					
Please choose your beneficiar	es						
Primary Beneficiaries (required)		Your Cost \$50.00					
Name	Percentage	Per month.					
My Estate (Employee)	%	Continue					
Sally Test (Spouse)	100 %						
Johnny Test (Son)	%						
Total	Total: 100%						
• Add New Beneficiary							
 Add Secondary Beneficiaries (opti Secondary beneficiaries receive money if your p 							
· · · · · · · · · · · · · · · · · · ·	,						

• Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

eview and Confirm					
Please Review			ton at right sid	e of the page	 Your Info Your Benefits Enroll Beneficiaries
Indicates changed benefits		Your To	tal Cost	\$0.00 Per Month	Other Coverages Review and Confirm
• Medical			Your cost per mo	onth \$0.00	4 Complete
A This benefit election	is pending until approve	d by your Benefits Administrator			Complete Enrollment
MESSA ABC Plan	1 Blue Cross Blue Shield of	Michigan	COST DETAILS	PER MONTH	
Who will be covered on th Name	iis plan: Relationship	Coverage 🚯	Your Cost	\$0.00	
Test User	Employee	Cover			
Spouse User	Spouse	Cover			

Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
On the right side of the screen click "Complete Enrollment."

Once You've Reviewed All Your Selections:	9	1
Participation	2	۱ E
I hereby acknowledge I have read the statements contained herein, or they have been read to me, and the statements are true and complete to the best of my knowledge. I understand any misrepresentation or omission contained herein may be used to reduce or deny a claim or void the contract if such misrepresentation or omission affects acceptance of the risk. I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible, under my employer's group contract(S). If any deductions for the coverages listed above are required, I authorize such deductions from my earnings and I understand that any premiums will be automatically deducted from my paycheck on a pre-tax basis (if eligible) unless I submit a declination election.	Ĭ	
I certify that the dependents listed satisfy the eligibility criteria for group benefit coverage. I know that I am responsible for removing any enrolled dependent immediately when that person becomes ineligible, and that I may be required to provide proof of my dependent's eligibility.	4	(
I agree, and I'm finished with my enrollment		C.



• A Confirmation Statement is presented and you may view, email or print the statement for your records.

•	Your enrollment is complete! You may make changes to your elections until: September 1, 2017						
	Please view your enrollment confirmation statement and verify that your selections are correct.						
	Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email" to email yourself a copy of the statement. If you would like to make changes to your enrollment selection, click the "Edit Selection" button located under each plan.						
	Your Confirmation Statement is ready Your Confirmation Statement is an overview of your new benefits and costs for your review and records.	VIEW MAIL PRINT					

REMINDER: All benefit elections must be accepted by your Benefits Administrator.

Spouse or Child Death

• Please contact your Benefits Administrator to remove a dependent due to death.

ELECTING BENEFITS

If you need to make changes to your benefits due to a qualifying event that is past the eligibility period of 30 days, contact your Benefits Administrator. If your Benefits Administrator approves the qualifying event, they will create a Special Enrollment Event for you.

Once the Event is created by the Benefits Administrator, follow the steps below:

- An enrollment window will display on the home page with the date the enrollment ends.
- Click "Start Your Enrollment."



- Review your demographic information and make any necessary changes. Click **"I agree"** and **"Continue."** •
- •

Employee Inform	ation		
	ment, all of your personal and family information must be complete. Please complete the required tion has already been entered, make sure it is accurate.		
Demographics			
* First Name	Mel		
Middle Initial			
* Last Name	Tester		
Suffix			
Social Security Number			
* Date of Birth	1/1/1980		
* Conder	O Male		
Gender	O Male O Pethale		
* Fields are required			
* Gender	O Male	•	Your Info
4 m 1 1 1 1 1		•	Employee Info
* Fields are required			Family Info
Address			Questions
Address 1	1475 Kendale Blvd	2	Your Benefits
Address 2		3	Enroll
City	East Lansing	4	Complete
State	MI - Michigan		
Zip	48823		Continue
* Home Phone	888-8888		
Cell Phone			
Home Email			
WORK CONTACT INFORM			
Work Phone Ext.			
* Work Email	melanie@junkmail.com		
	Home Email O Work Email		
* Fields are required			
By checking the box "I Agree" I	pelow, you agree that the information above is accurate to the best of your knowledge.		
I agree			

- Review your family information make any necessary changes.
 - o If the qualifying event includes adding a spouse and/or dependent, click "Add Dependents".
 - Enter the required information for the spouse/dependent.
 - Click **"Save & Continue".**

Dependent Demographic			
* First Name			
Middle Initial			
*Last Name			
Suffix			
* Date of Birth (mm/dd/yyyy)			
* Social Security Number) 1000-00000			
(* Gender) O Male O Female			
* Relationship			
* Fields are required			
	Cancel	Save & Add Another	(Save & Continue)

- Read the "Dependent Information Notice" and click "I agree."
- Click "Continue."

Family Information	n		
already been entered, click or	the person's name. nily members have a foreign (non-US	o verify or edit the information of a family member who has 5A issued) SSN, please contact your Benefits Administrator or	Your Info Employee Info Femily Info Questions
Mel Tester Female Employee 36 years old (1/1/1980) 5534	Markese Tester Male Son 27 years and (8:8/1088) 8:3N	Add Dependents	Your Benefits Gomplete Continue
are not included) until a ma NOTE: Your child's spouse an Your children beyond the e year of their 20th birthday upon you for a majority of disability or physical hand considered as a basis for o Your children beyond the e year of their 20th birthday support. Your sponsored dependent the internal Revenue Code,	- le dependents include: spchildren, adopted children, and chil aximum of the end of the calendar ye d your grandchildren are not covered and of the calendar year of their 26th i and continuously thereafter) who are their support and who are incapable of cap. (Under no circumstance will me ontinued coverage.) Please contact I and of the calendar year of their 26th i and continuously thereafter) who are ts who are members of your family, e were declared as dependents on you it tax year. (Children who are no long		dar at at dar r dar ing

Note: You will only see this step if you have PAK or Bundled benefits. If you do not have these benefits, continue to the next step.

- You will be presented with the question "What PAK/Bundle of Coverage do you want?"
- Review the benefits in each PAK/Bundle and scroll to the bottom and select the PAK/Bundle of coverage you wish to enroll in and click **"Continue"** on the right-hand side of the screen.

Questions	
*What PAK of Coverage do you want? PAK A Medical – MESSA Choices \$200/\$400 Dental - Dent 80/60/60/60A:1300/1000:2 Marian MCD 2	1 Your Info Employee Info Family Info
Vision - VSP 2 Negotiated LTD PAK Life - \$20,000 PAK Life PAK AD&D - \$20,000 PAK AD&D Basic Term Life - \$5,000 PAK B Dental - Dent 80/80/80/1300/1000:2	Questions Your Benefits Enroll Complete
Vision - VSP 3 Negotiated LTD PAK Life - \$30,000 PAK Life PAK AD&D - \$30,000 PAK AD&D PAK C Medical – MESSA ABC Plan 1	Continue
Dental - Dent 80/80/80/80:1300/1000:2 Vision - VSP 2 Negotiated LTD PAK Life - \$20,000 PAK Life PAK AD&D - \$20,000 PAK AD&D Basic Term Life - \$5,000	
 I want Pak A. I want Pak B. I want Pak C. * Fields are required	

• Click on "View Plan Options" to the right of each plan name.

Medical	NO PLAN SELECTED
* Selection Required	View Plan Options

- To cover a dependent, check the box next to their name.
- To remove a dependent, uncheck the box next to their name.
- Click "Continue".

Who will be covered by this plan?	
Gabriel Test Employee Paige Test Spouse Son Vot Covered	
Seck to Benefits	Continue

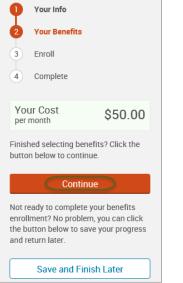
• Select the benefit plan by clicking "Select" or "Keep Selection".



• If you wish to waive (remove) a benefit plan, click "I don't want this benefit (waive)."

•	Medical				\$50.00 💌 Your Cost per month
		MESSA ABC Plan 1 Employee + Family	/ Blue Cross Blue Shield of	Michigan / View plan detail	S
		Daniel Test Susan Test John Test	Employee Spouse Son	CoverCoverCover	
	Completed		Ido	n't want this benefit (waive)	View Plan Options

• When finished going through every benefit plan, click "**Continue**" on the right-hand side.



• You will be required to designate at least one primary beneficiary information when you have life insurance.

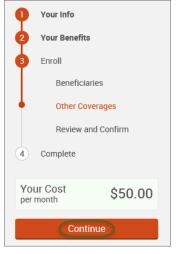
- Dependents will automatically appear for you to designate, however you may also "Add New Beneficiary" if you'd like to designate someone other than a dependent.
- Primary beneficiaries are required, secondary (contingent) beneficiaries are not required.
- Percentage total must equal 100%.
- When finished click "Continue."

		Your Info			
Please verify your beneficiary information is comp	2 Your Benefits				
	"Beneficiary" represents the person or persons designated in writing and in accordance with the terms of the plan to receive any due benefits after the death of an employee/retiree. "Secondary beneficiary" represents the person or persons named to receive benefits if the primary beneficiary is deceased.				
		Beneficiaries			
		Other Coverages			
Basic Term Life		Review and Confirm			
Please choose your beneficial	ries	4 Complete			
Primary Beneficiaries (required)		Your Cost \$50.00			
Name	Percentage				
My Estate (Employee)	%	Continue			
Sally Test (Spouse)	100 %				
Johnny Test (Son)	%				
Tota	l: 100%				
Add New Beneficiary					
 Add Secondary Beneficiaries (opt Secondary beneficiaries receive money if your 					
occondary beneficialles receive money if your	printing selected and analytic to finite it.				

- If you and/or a dependent are enrolled in MESSA medical coverage and have other medical coverage, you will be required to enter information about the other coverage.
- Click "Yes" next to "Current or Prior Coverages" and enter the following information.
- Once you have entered the information, click "Save."

Medical	
John Test (Employee) Other Medical Insurance Coverag	e.
Current or Prior Coverages Other Insurance	● Yes ○ No New ✓
Policyholder Name	
Policy Number	
Policyholder's Employer	
Policyholder's Employer Address	
Policyholder's Employer Phone	555-555-5555
Insurance Carrier's Name	
Insurance Carrier's Phone	555-555-5555
Coverage Start Date	mm/dd/yyyy
Coverage End Date	mm/dd/yyyy
State/Country of Coverage	✓
Coverage Level	Employee 🗸
Additional Info	
Save	

• If you do not have other medical coverage, keep "Current or Prior Coverages" as "No" and click "Continue".



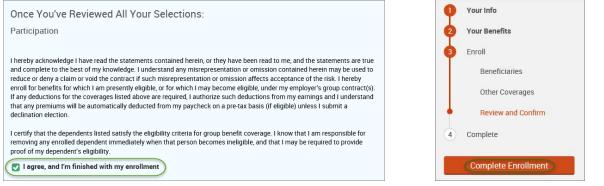
• Now that you have elected all your benefits, please review your elections and scroll to the bottom of the page.

Review and Confirm

.

D	Please Review	w All of Your S	elections			2	Your Info Your Benefits
Once you have completed your review, click the "Complete Enrollment" button at right side of the page					3	Enroll	
nce y	ou have completed y	our review, click the	complete Enrollmen	it button at right s	side of the page		Beneficiaries
ndicate	es changed benefits				\$0.00		Other Coverages
			Ye	our Total Cost	Per Month	•	Review and Confirm
•	Medical			Your cost per	month \$0.00	4	Complete
	A This benefit election	on is pending until approve	d by your Benefits Adminis	trator			Complete Enrollment
MESSA ABC Plan 1 Blue Cross Blue Shield of Michigan		Michigan	COST DETA	ILS PER MONTH			
	Who will be covered on	this plan:		Your Cos	t \$0.00		
	Name	Relationship	Coverage 🚯				
	Test User	Employee	Over				
	Spouse User	Spouse	Cover				

- Review the "Participation" statement and check the "I agree, and I'm finished with my enrollment" box.
- On the right side of the screen click "Complete Enrollment."



A Confirmation Statement is presented and you may view, email or print the statement for your records.

Your enrollment is complete! You may make changes to your elections until: September 1, 2017 Please view your enrollment confirmation statement and verify that your selections are correct. Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email" to email yourself a copy of the statement. If you
Click the "Print" button to print a copy of your enrollment confirmation statement for your records, click "Email" to email yourself a copy of the statement. If you would like to make changes to your enrollment selection, click the "Edit Selection" button located under each plan. Your Confirmation Statement is ready Image: Click the "Edit Selection" button located under each plan. Your Confirmation Statement is ready Image: Click the "Edit Selection" button located under each plan. Your Confirmation Statement is no overview of your new benefits and costs for your review and records. Image: Click the "Edit Selection" button located under each plan.

REMINDER: All benefit elections must be accepted by your Benefits Administrator.

CANCELLING MESSA BENEFITS

If you would like to cancel <u>all</u> MESSA benefits, please see your benefits administrator.

CONFIRMATION STATEMENTS

You have the ability to view/print a confirmation statement for any given effective date at any time.

- Click on "My Profile" to see your demographic (personal) information.
- Select "Personalized Forms."



- Enter the effective date of the confirmation statement you are requesting.
- Click **"View."**

Personalized Forms				
💄 Melanie Test				
Title	Effective Date	End Date	Show COB	View

- You will get a pop-up that asks you if you want to open or save the confirmation statement.
- Click "Open."

Do you want to open or save Enrollment Confirmation Form.pdf (120 KB) from secure.bswiftsandbox.com?	Open	Save 🔻	Cancel	×	

• Your confirmation statement will open for you to view and/or print.



New Elections, Confirmation Statement for Melanie Test

We are pleased to provide you with this personalized summary of your benefit enrollment elections and payroll deductions. For more information about your benefits, please log into www.messa.org and click on My Benefits. If you have any questions, call MESSA at 800.336.0013.

Your Benefits as of 8/1/2016

Coverage: \$5,000.00

TOTAL COSTS PER MONTH \$0.00 Your Cost Your cost per month \$0.00 Medical MESSA Choices \$200/\$400 Cost Details Per Month Coverage: Employee + Family \$0.00 Who will be covered on this plan: Your Cost Coverage 🔒 Name Relationship Covered Melanie Test Employee Spouse Test Walved Spouse NOT COVERED Baby Test Daughter Your cost per month \$0.00 Vision VSP 2 Cost Details Per Month Coverage: Employee + Dependent \$0.00 Who will be covered on this plan: Your Cost Relationship Coverage 🔒 Name Covered Melanie Test Employee Spouse Test Spouse Covered NOT COVERED Baby Test Daughter Your cost per month \$0.00 Basic Term Life Basic Term Life with Medical Cost Details Per Month

\$0.00

Your Cost

EMPLOYEE FILE DOCUMENTS

You have the ability to upload documents to MESSA's online benefits website (birth certificate, marriage license, etc.). These documents will be viewable to you and your employer.

UPLOADING DOCUMENTS

- From your home page, click on "My Profile" to see your demographic (personal) information.
- Select **"Employee File."**

f	My Benefits 🗸	My Profi	le	User Guide
Pe	rsonal Information			
Fai	nily Information			
Bei	neficiaries			
Sec	curity Question			
Life	e Event			
Em	ployee File			
Per	rsonalized Forms			

• Click on **"View and Upload Documents"** next to the name of the person that the uploaded documents pertain to. If document applies to the entire family put under the employee's name.

Employee File							
Jackson Test Em	ployee						
Name	Relationship	Date of Birth	View and Upload				
Jackson Test	EMPLOYEE	01/01/1985	View and Upload Documents				
Uploaded Docum	Uploaded Documents						
Descri							
Search Cancel	Reset Fields						

- Enter the title of your document.
- Enter the Document Type.
- Click "Browse" and search for your document on your computer.
- Click "Save".

File Upload		
Wife Test Spouse		
(* Title)		
Description		
* Document Type	Unspecified 🗸	
* File		Browse
* Fields are required		
Save Cancel		

VIEWING UPLOADED DOCUMENTS

- From your home page, click on "My Profile" to see your demographic (personal) information.
- Select "Employee File."



• Documents that have been uploaded will show at the bottom of the screen. To view them click on the link on the right side of the document.

File Upload			
Wife Test Spous	e		
* Title			
Description			
* Document Type	Unspecified 🗸		
* File			Browse
* Fields are required			
Save Cancel			
		10 items per page 🗸	1 to 1 of 1 rows
Title 🗘 D	Description 🗘 Document Type	Saved On	♦ Saved By ♦ View ♦
Birth Certificate	Unspecified	8/15/2017 7:46:08 AI	M MESSA Trainers View

QUESTIONS

If you have any questions, are having trouble logging into the website or you cannot reset your password, please contact your MESSA Member Services at 800.336.0013.