

A nonprofit corporation and independent licensee

of the Blue Cross and Blue Shield Association



MESSA ABC Plan 2

20% Coinsurance

Summary of Benefits and Coverage: What this Plan Covers & What it Costs*

Coverage Period: Beginning on or after 01/01/2017 **Coverage for:** Individual / Family

Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.messa.org or by calling MESSA at 800-336-0013.

Important Questions	Answers		Why this Matters:	
	In-Network	Out-of-Network	with this matters.	
What is the overall <u>deductible</u> ?	\$2,000 Individual/ \$4,000 Family	\$4,000 Individual / \$8,000 Family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .	
Are there other <u>deductibles</u> for specific services?	No.	No.	You don't have to meet deductibles for specific services, but see the Common Medical Event chart starting on page 2 for other costs for services this plan covers.	
Is there an <u>out-of-pocket</u> <u>limit</u> on my expenses?	\$4,000 Individual/ \$6,550 Family	\$8,000 Individual / \$16,000 Family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.	
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> <u>limit</u> .	
Is there an overall annual limit on what the plan pays?	No.		The Common Medical Events chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.	
Does this plan use a <u>network</u> of <u>providers</u> ?	Yes. For a list of in-network providers, see <u>www.messa.org</u> or call MESSA at 800-336-0013.		If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in- network, preferred , or participating for providers in their network . See the Common Medical Events Chart starting on page 2 for how this plan pays different kinds of providers .	
Do I need a referral to see a <u>specialist</u> ?	No.		You can see the specialist you choose without permission from this plan.	
Are there services this plan doesn't cover?	Yes.		Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .	

MESSA ABC, Group Number 71452, 71453; 174 175

Questions: Call MESSA at 800-336-0013 or visit us at <u>www.messa.org</u>. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/healthreform or call MESSA at 800-336-0013 to request a copy.

*This plan or selected benefits within this plan are underwritten by 4 Ever Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association and administered by Blue Cross Blue Shield of Michigan. 1 of 9

- <u>**Co-payments</u>** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.</u>
 - <u>Co-insurance</u> is *your* share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For example, if the plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>co-insurance</u> payment of 20% would be \$200. This may change if you haven't met your <u>deductible</u>.
 - The amount the plan pays for covered services is based on the <u>allowed amount</u>. If an out-of-network <u>provider</u> charges more than the <u>allowed amount</u>, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <u>allowed amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u>.)
 - This plan may encourage you to use in-network **providers** by charging you lower **<u>deductibles</u>**, **<u>co-payments</u>** and <u>**co-insurance**</u> amounts.

Common		Your cost if you use a		
Medical Event	Services You May Need	In-Network Provider	Out-of-Network Provider	Limitations & Exceptions
	Primary care visit to treat an injury or illness	20% co-insurance after deductible	40% co-insurance after deductible	none
If you visit a health care	Specialist visit	20% co-insurance after deductible	40% co-insurance after deductible	none
provider's office or clinic	Other practitioner office visit	20% co-insurance after deductible for chiropractor	40% co-insurance after deductible	Limited to a maximum of 38 visits per member per calendar year for spinal manipulations.
	Preventive care/screening/ immunization	No Charge	Not Covered	none
If you have a	Diagnostic test (x-ray, blood work)	20% co-insurance after deductible	40% co-insurance after deductible	none
test	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	40% co-insurance after deductible	Imaging subject to preauthorization.
If you need drugs to treat your illness or	Generic or prescribed over- the-counter drugs	\$10 co-pay after deductible for retail 34-day supply; \$20 co-pay after deductible for retail and mail order 90 day supply.	\$10 Co-pay plus an additional 25% of BCBSM approved amount for the drug.	
condition For more information about	Preferred brand-name drugs	\$40 co-pay after deductible for retail 34-day supply; \$80 co-pay after deductible for retail and mail order 90 day supply.	\$40 Co-pay plus an additional 25% of BCBSM approved amount for the drug.	For information on women's contraceptive coverage, go to <u>www.messa.org</u> . Mail order drugs are not covered out-of-network.
prescription drug coverage, go to <u>www.messa.org</u> .	Non-Preferred brand-name drugs	\$40 co-pay after deductible for retail 34-day supply; \$80 co-pay after deductible for retail and mail order 90 day supply.	\$40 Co-pay plus an additional 25% of BCBSM approved amount for the drug.	

Common		Your cost if	you use a	
Common Medical Event	Services You May Need	In-Network Provider	Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	40% co-insurance after deductible	none
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	none
If you need immediate medical attention	Emergency room services	20% co-insurance after deductible	20% co-insurance after deductible	Co-pay waived if admitted.
	Emergency medical transportation	20% co-insurance after deductible	20% co-insurance after deductible	none
	Urgent care	20% co-insurance after deductible	40% co-insurance after deductible	none
If you have a	Facility fee (e.g., hospital room)	20% co-insurance after deductible	40% co-insurance after deductible	none
hospital stay	Physician/surgeon fee	20% co-insurance after deductible	40% co-insurance after deductible	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	none
	Mental/Behavioral health inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	none
	Substance use disorder outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	none
	Substance use disorder inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	none
If you are pregnant	Prenatal and postnatal care	Prenatal: No charge Postnatal: 20% co-insurance after deductible	40% co-insurance after deductible	none
	Delivery and all inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	none

Common	Services You May Need	Your cost if	you use a	Limitations & Exceptions
Medical Event		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Home health care	20% co-insurance after deductible	20% co-insurance after deductible	none
	Rehabilitation services	20% co-insurance after deductible	40% co-insurance after deductible	Physical, Occupational, Speech therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	20% co-insurance after deductible	40% co-insurance after deductible	Applied behavioral analysis (ABA) treatment for Autism – when rendered by an approved board-certified analyst - is covered through age 18, subject to preauthorization.
	Skilled nursing care	20% co-insurance after deductible	20% co-insurance after deductible	Limited to a maximum of 120 days per member per calendar year.
	Durable medical equipment	20% co-insurance after deductible	20% co-insurance after deductible	none
	Hospice service	20% co-insurance after deductible	20% co-insurance after deductible	none
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	none
	Glasses	Not Covered	Not Covered	none
	Dental check-up	Not Covered	Not Covered	none

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

Cosmetic surgery ٠

Routine eye care (Adult) • Routine foot care

•

- Dental care (Adult) ٠
- Long-term care ٠

Weight loss programs •

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture ٠
- Bariatric surgery ٠
- Chiropractic care ٠
- Coverage provided outside the United States. See www.messa.org ٠
- Hearing aids ٠
- If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement ٠ (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, co-payments, or co-insurance, or benefits not otherwise covered.
- Infertility treatment ٠
- Private-duty nursing •

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan by calling MESSA at 800-336-0013. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <u>www.dol.gov/ebsa</u>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to <u>appeal</u> or file a <u>grievance</u>. For questions about your rights, this notice, or assistance, you can contact MESSA Legal and Compliance by calling 1-800-742-2328. Or, you can contact Michigan Office of Financial and Insurance Regulation at <u>www.michigan.gov/ofir</u> or 1-877-999-6442. For group health coverage subject to ERISA, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage <u>does meet</u> the minimum value standard for the benefits it provides. (<u>IMPORTANT</u>: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: See Addendum

4 Ever Life Insurance Company is the underwriter of this plan or selected benefits within this plan. Blue Cross Blue Shield of Michigan does not underwrite or assume any financial risk with respect to the claims liability associated with any 4 Ever Life underwritten health care products, as BCBSM is an administrator for 4 Ever Life products. 4 Ever Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association, is a wholly owned subsidiary of BCS Financial Corporation.

-To see examples of how this plan might cover costs for a sample medical situation, see the next page.-

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much insurance protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Please note: Coverage Examples are calculated based on individual coverage and calculations may not include a coinsurance maximum.

Having a baby (normal delivery)

Amount owed to providers: \$7,540

Plan pays \$4,740

You pay \$2,800

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$2,000
Co-pays	\$20
Co-insurance	\$630
Limits or exclusions	\$150
Total	\$2,800

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

Amount owed to providers: \$5,400

Plan pays \$2,770

You pay \$2,630

Sample care costs:

Prescriptions	\$2,900
Medical Equipment & Supplies	\$1,300
Office Visits & Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$2,000
Co-pays	\$290
Co-insurance	\$260
Limits or exclusions	\$80
Total	\$2,630

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S.
 Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from innetwork **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how <u>deductibles</u>, <u>co-</u> <u>payments</u>, and <u>co-insurance</u> can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are <u>not</u> cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your <u>providers</u> charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

 ✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-ofpocket costs, such as <u>co-payments</u>, <u>deductibles</u>, and <u>co-insurance</u>. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Language services

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

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

محسن المال علم فتراحب مدع است رخ صخش و أتن أتنك اذا كت غلب تامول عمل و قدع اسمل الملع لو صرح الحقّك نمف المحصّص مقرل اب التصل ،مجرتم على التحدّث تفلك أي نو دب المحصّص مقرل اب التصل ،مجرتم على التحدّث تفلك أي نو دب المحصّص مقرل اب التصل ،مجرتم مل التحدث المحكم المحصّص مقرل اب التصل ،مجرتم على التحدث المحكم المحصّص مقرل اب التصل ،مجرتم على التحدث المحصّص مقرل اب التصل ،مجرتم على التحدث المحصّص مقدل المحمو المحصّم مقدل المحمو المحموة ا

Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ, cần sự giúp đỡ, quý vi có quyền được trợ giúp và nhân thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, hãy gọi đến số dịch vụ thành viên MESSA trên mặt sau của thẻ. Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të dreitë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e shërbimit të anëtarësimit MESSA në anën e pasme të kartës tuaj. 귀하 또는 귀하가 도움을 제공하는 누군가가 도움이 필요한 경우, 귀하는 귀하의 모국어로 무료로 도움과 정보를 제공 받을 권리를 갖고 있습니다. 통역사의 도움을 받으려면 카드 뒷면의 MESSA 회원 서비스 번호로 전화하십시오. אור רייז דרא לאגר מרצר רא מר ייי

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যদি আপনার বা আপদন সাহাযয কররন এমন কাররা সহায়তার প্ররয়াজন হয়, তাহরে ককারনা খরচ ছাড়াই আপনার ভাষায় সহায়তা ও তথ্য পাওয়ার অদিকার ররয়রছ। ককারনা কিাভাষীর সারখ্ কথ্া বেরত, আপনার কারডের কপছরন প্রিত্ত MESSA সিসয

পদররষবার নম্বরর কে করুন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi członków MESSA wskazany na odwrocie Twojej karty.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigen, haben Sie das Recht kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer der MESSA-Mitgliederbetreuung auf der Rückseite Ihrer Karte an. Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere gratuitamente aiuto e informazioni nella tua lingua. Per parlare con un interprete, chiama il numero del servizio membri MESSA presente sul retro della tua tessera.

ご本人様、またはお客様の身の回りの方で支援 を必要とされる方でご質問がございましたら、 ご希望の言語でサポートを受けたり、情報を入 手したりすることができます。料金はかかりま せん。通訳とお話される場合はお持ちのカード の裏面に記載されたMESSAメンバーサービスの 電話番号までお電話ください。

Если Вам или лицу, которому Вы помогаете, нужна помощь, то Вы имеете право на бесплатное получение помощи и информации на Вашем языке. Для разговора с переводчиком позвоните по номеру телефона MESSA отдела обслуживания клиентов, указанному на обратной стороне Вашей карты.

Ukoliko je vama ili nekom kome pomažete potrebna pomoć, imate pravo dobiti pomoć l informaciju na vašem jeziku besplatno. Da biste razgovarali sa prevodiocem, pozovite broj za ulsuge članova MESSA na zadnjoj strani vaše kartice. Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang interpreter, tumawag sa numero para sa mga serbisyo sa miyembro ng MESSA na nasa likuran ng iyong card.

Important disclosure

MESSA and Blue Cross Blue Shield of Michigan (BCBSM) comply with federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. MESSA and BCBSM provide free auxiliary aids and services to people with disabilities to communicate effectively with us, including qualified sign language interpreters. If you need assistance, call MESSA's Member Service Center at 800.336.0013 or TTY 888.445.5614. If you need help filing a grievance, MESSA's general counsel is available to help you. If you believe that MESSA or BCBSM failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, or by mail, phone, fax or email: General Counsel, MESSA, P.O. Box 2560, East Lansing, MI 48826-2560, 800.292.4910, TTY: 888.445.5613, fax: 517.203.2909 or CivilRights-GeneralCounsel@messa.org.

You can also file a civil rights complaint with the Office for Civil Rights on the web at <u>OCRComplaint@hhs.gov</u>, or by mail, phone or email: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, 800.368.1019, TTD: 800.537.7697, or <u>OCRComplaint@hhs.gov</u>.