



messa

ACCOUNT-BASED CHOICES

ABC

Plan 1

Document Version 9/14

P l a n C o v e r a g e G u i d e

Dear MESSA Member,

Welcome to MESSA's low-premium, high-deductible health plan, MESSA ABC. MESSA ABC is an exceptional, high-quality health plan that costs less and gives you the same great financial security, peace of mind and personalized service that are at the heart of every MESSA plan.

MESSA ABC is also compatible with a Health Savings Account (HSA). By packaging MESSA ABC with a higher deductible and an HSA, we're able to reduce your premiums and give you significant savings right away – so you can keep more money in your paycheck and put the rest to work building a tax-free nest egg to cover future medical expenses – even into your retirement.

We've taken special care to build extra features into MESSA ABC that support your good health and give you powerful tools to minimize your costs and maximize your benefits. Special coverages include:

- **Free coverage on hundreds of preventive prescriptions.** Under the federal law governing plans like MESSA ABC, prescription drug costs are subject to the plan deductible. However, you won't have to pay a dime for a preventive prescription on the MESSA ABC preventive Rx list.
- **Free preventive care from in-network providers, including annual physicals and vaccinations.**
- **Access to the state's largest provider networks.**
- **A low, annual out-of-pocket maximum that caps your costs for in-network services – giving you greater financial certainty and peace of mind.**
- **Referrals to **Mayo Clinic** and other renowned medical experts when you need them.**
- **An easy-to-use, online Health Savings Account from MESSA's HSA partner, HealthEquity. And there's no monthly fee for MESSA ABC members.**

Your future is safe and secure with MESSA ABC. Its coverage is exceptional and it gives you instant savings on premiums. Find out more at www.messa.org or call MESSA's East Lansing-based Member Service Center at 800.336.0013.

Sincerely,

Cynthia Williams
MESSA Executive Director

MESSA ABC qualifies under federal law as a Health Savings Account (HSA)-compatible plan.

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MESSA ABC Rx Plan (Prescription Drug Booklet)

MESSA Resources

Confirmation Statement

When you first enroll or when your benefits change, MESSA will mail a Confirmation Statement to your home address. It will list all the benefits for which you are enrolled.

Your Medical Plan Coverage Guide

This booklet is designed to help you understand your medical and prescription drug coverage under the MESSA ABC Plan. Please take time to read it to ensure you understand what services are covered and when you are responsible for out-of-pocket costs. Occasionally state or federal laws require changes to medical coverage. When such changes occur, the medical plan coverage guide will be revised and posted on the web at www.messa.org.

This document is not a contract. Rather, it is intended to be a summary description of benefits. Every effort has been made to ensure the accuracy of this information. However, if statements in this description differ from the applicable coverage documents, then the terms and conditions of those documents will prevail.

Your Medical Plan Highlights

A two-page summary of your plan coverage is available at www.messa.org/MESSAABCs under the Information Library. You can also get a copy from your school business office or by calling MESSA at 800.336.0013.

Register for your secure member web account at www.messa.org

Simply follow the instructions on the home page to register for access to your personalized coverage information and other helpful resources found under the MEMBERS tab:

- ▶ Medical Plan Highlights: click My Benefits and then click on the underlined MESSA ABC link. You can also click on any additional benefits you are enrolled in for further information on that specific coverage.
- ▶ Listing of your covered dependents, the coverage you are enrolled in, copayment, coinsurance and deductible requirements and deductible status.
- ▶ View and print your Explanation of Benefit (EOB) forms
- ▶ Access your prescription account history
- ▶ Change your address
- ▶ Request Medical ID Cards
- ▶ Email MESSA
- ▶ Access various forms for medical claims, enrollment, etc.

On the MESSA website you can also access an entire suite of Healthy Living programs, tools and information through Mayo Clinic's EmbodyHealth portal and much more. Explore, have fun and be well!

MESSA Member Services – 800.336.0013

MESSA employees take pride in our reputation for providing outstanding member service. We have a statewide network of Field Representatives and dozens of benefit specialists who answer our telephone lines and assist members with their claims and benefit questions. Please do not hesitate to call us at 800.336.0013 if you have a question or concern about your MESSA coverage.

Once again, welcome to MESSA!

How to Contact Us

You can call, e-mail, visit, or write the MESSA Member Service Center when you have benefits and claims processing questions.

By phone

Our award-winning Member Service Center is here to help you. Please call us toll-free at 800.336.0013, or, in the East Lansing area at 517.332.2581.

By e-mail

Visit our website at www.messa.org. From our website you may submit a message to our Member Service Center using a secured form. A Member Service Specialist will respond to your inquiry within two business days.

In person

We welcome you to visit our office at 1475 Kendale Blvd. in East Lansing so we may answer your claim or benefit inquiries in person. Visit our website for directions to our location.

By mail

Please send all correspondence to:

MESSA
1475 Kendale Blvd.
P.O. Box 2560
East Lansing, MI 48826-2560

To help us serve you better

Here are some important tips to remember:

- ▶ Have your medical insurance ID card handy so you can provide your enrollee ID/contract number. If you are writing to us, include this information in your correspondence.
- ▶ To ask if a particular service is covered, please have your physician provide you with the five-digit procedure code and diagnosis. If your planned procedure does not have a code, obtain a complete description of the service in addition to the diagnosis.

NOTE: Benefits cannot be guaranteed over the phone.
- ▶ To inquire about a claim, please provide the following:
 - Patient's name
 - Provider's name (such as the doctor, hospital or supplier)
 - Date the patient was treated
 - Type of service (for example, an office visit)
 - Charge for the service
- ▶ When writing to us, please send copies of your bills, other relevant documents, and any correspondence you have received from us. Make sure you keep your originals.
- ▶ Include your daytime telephone number as well as your enrollee ID/contract number on all correspondence.

Your MESSA ABC Preferred Provider Organization (PPO) Plan – How it Works

Health care benefits provided under the MESSA ABC PPO plan are underwritten by Blue Cross Blue Shield of Michigan (BCBSM) and 4Ever Life. There are different levels of benefits for in-network and out-of-network services.

In-network providers

To receive care with the lowest out-of-pocket costs, choose providers from the PPO network. By staying in-network, members pay less out-of-pocket and receive more comprehensive benefits.

The network is made up of physicians, hospitals and other health care specialists who have agreed to accept our approved amount as payment in full for covered services. When you receive services from a PPO network provider, your out-of-pocket costs are limited to in-network deductibles. Exceptions are for MESSA-specific benefits such as chiropractic modalities since these services are not covered by BCBSM. Even in-network providers are not required to accept our payment as payment in full for these services. Please discuss this with your provider before receiving services.

Most services for preventive care are only covered when provided by an in-network provider.

How to find in-network providers

To choose a doctor:

- ▶ Visit www.messa.org to find physicians who are in-network, or
- ▶ Call MESSA's award-winning Member Service Center for assistance in finding in-network providers at 800.336.0013, or
- ▶ Ask your doctors if they are in-network. Always ask first to avoid "surprise" billings.
- ▶ Ask your specialists if they are in-network. You should also ask specialists and surgeons who are providing follow-up care to an emergency room visit if they are in-network.

Out-of-network providers

When you receive care from a provider who is not part of the PPO network, without a referral from a PPO provider, your care is considered out-of-network. For most out-of-network services, you have higher deductibles and coinsurance as well as responsibility for amounts in excess of the approved amount.

Services for preventive care are not covered out-of-network.

Referrals to out-of-network providers

Your in-network PPO provider should refer you to another in-network PPO provider when available.

If an in-network provider is not available, the referring provider should refer you to a participating provider. This is a provider who accepts BCBSM.

In the event you are referred to an out-of-network provider, even if he or she is a participating provider, the in-network provider must provide a PPO Program referral form for the claim to be paid as in-network. A referral is only valid when it is obtained before the referred services are provided. The referring physician

should complete the form and provide copies to you and the physician to whom you were referred. A verbal referral is not acceptable. The form can be found at:

https://www.messa.org/Portals/o/PDF/ppo_referral_form.pdf

Out-of-network “participating” providers

If you choose to receive services from an out-of-network provider, you can still limit your out-of-pocket costs if the provider participates with BCBSM.

When you use participating providers:

- ▶ You will pay the out-of-network deductible and coinsurance.
- ▶ You will not have to submit a claim. The provider will bill us directly for your services.
- ▶ You will not be billed for any differences between our approved amount and their charges. Exceptions are for MESSA-specific benefits such as chiropractic modalities. Since these services are not covered by BCBSM, participating providers are not required to accept our payment as payment in full. Please discuss this with your provider before receiving services.

Out-of-network “non-participating” providers

Non-participating providers are providers who are not in the PPO network and do not participate with us. If you receive services from a non-participating provider, in addition to the out-of-network deductible and coinsurance, you may also be responsible for any charges above the approved amount. Providers who do not participate with us are not required to accept the approved amount as payment in full for covered services. The additional charges may be significant.

When you use non-participating providers, you may be responsible for payment at the time of service in addition to filing your own claim. You can either submit the requirements yourself as outlined on [page 39](#) or complete the [claim form provided here](#). MESSA will reimburse the approved amount, less the out-of-network deductible and coinsurance.

Approved Amount

In-network and out-of-network doctors and facilities who participate with Blue Cross Blue Shield of Michigan will accept the approved amount as payment in full after deductible and coinsurance. More than 80 percent of Michigan physicians are in the network. PPO networks save you money because those hospitals and doctors agree to accept discounted fees. This also helps you and your group save on premiums.

Non-participating doctors and facilities have no such agreements and you are responsible for payment to them for charges in excess of our approved amount.

What happens if your PPO physician leaves the network?

Your physician is your partner in managing your health care. However, physicians retire, move or otherwise cease to be affiliated with the PPO network. If this happens, your physician should notify you that he or she is no longer in the PPO network. If you have difficulty choosing another physician, please contact the MESSA Member Service Center for assistance. If you wish to continue care with your current physician, a Member Service Representative will explain the financial costs to you when services are performed by a physician who is no longer in the PPO network.

Care outside of Michigan

We participate with other Blue Cross and/or Blue Shield plans in the BlueCard PPO Program. This program offers members of Blue Cross and/or Blue Shield plans medical benefits when they receive health care from BlueCard PPO providers outside the area their local plan services. If you or a covered dependent receive treatment in an accredited non-Michigan hospital, just show your MESSA/BCBSM identification card. The hospital billing office will send the bill directly to MESSA or the local Blue Cross plan.

If you or a covered dependent receives any other type of service performed by a physician practicing outside of Michigan, the physician's billing office will either bill the local Blue Cross plan directly or provide you with an itemized statement or receipt. Send these itemized statements to MESSA.

BlueCard PPO network provider

If you receive covered services from a BlueCard PPO network provider:

- ▶ The provider will file your claim with the local Blue Cross and/or Blue Shield plan (Host Plan). Your plan's in-network deductibles and copayments will apply.

BlueCard out-of-network providers

If the provider is not a BlueCard provider, the Host Plan will apply benefits at your plan's out-of-network level, including deductible and coinsurance.

If you were referred to that provider by a PPO network provider or needed care for an accidental injury or medical emergency, in-network benefits will apply.

BlueCard providers may not be available in some areas. In areas where they are not available, you can still receive BlueCard benefits if you receive services from a BlueCard participating provider. The Host Plan must notify BCBSM of the provider's status.

BlueCard Worldwide Program

The BlueCard Worldwide Program assists BCBSM members traveling or living outside of the United States in obtaining medical care services, provides access to a worldwide network of health care providers, and includes claims support services.

NOTE: A PPO network is not available outside the United States.

In this BlueCard Worldwide Program Section, when we refer to participating or non-participating hospitals or physicians, we mean participating or non-participating in the BlueCard Worldwide Program.

Medical Assistance Services

If subscribers need medical services while traveling or living outside of the United States, they are responsible for contacting the BlueCard Worldwide Service Center at 800.810.BLUE (or call collect at 804.673.1177 if they are calling from outside the United States) to assist them with information on participating hospitals and physicians and by providing medical assistance services. Failure to contact the BlueCard Worldwide Service Center could result in payment reductions or nonpayment of services.

Medically Necessary

A service must be medically necessary to be covered. "Medically Necessary" is defined in the [Glossary of Health Care Terms](#).

Deductibles

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Calendar year 2014: \$1,250 for Single Coverage, \$2,500 for 2-Person & Family	Calendar year 2014: \$2,500 for Single Coverage, \$5,000 for 2-Person & Family	Combined with out-of-network
Calendar year 2015: \$1,300 for Single Coverage, \$2,600 for 2-Person & Family	Calendar year 2015: \$2,600 for Single Coverage, \$5,200 for 2-Person & Family	

A deductible is the amount you pay each calendar year before your insurance benefits are paid.

Your deductible applies to all services and prescription drug purchases except certain preventive care and specific preventive prescriptions. When two or more lives are covered under this plan, the entire family deductible must be met before claims are paid for any individual. This is mandated by federal law for an HSA-qualified plan.

Some services do not have a network. Examples include but are not limited to: home health care agencies, hospice, etc. In these cases the out-of-network deductible is waived and the in-network deductible applies.

NOTE: MESSA ABC plans do not have 4th-quarter deductible carryover.

Annual Out-of-pocket Maximums (includes deductible, Rx copayments and coinsurance)

NOTE: Charges in excess of the approved amount and those for services not covered by the plan do not apply toward your out-of-pocket limits.

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Deductible plus \$1,000 for Single Deductible plus \$2,000 for 2-Person & Family	Deductible plus \$2,000 for Single Deductible plus \$4,000 for 2-Person & Family	Combined with out-of-network

Copayments

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
The in-network deductible must be met first. After the deductible, the only copayments are for prescription drugs. There are no copayments on medical services after the deductible.	The out-of-network deductible must be met first. Then 20% coinsurance applies.	The out-of-network deductible must be met first. Then 20% coinsurance applies. Non-participating providers may also bill you for fees above the approved amount. These fees are not covered by your plan, nor do they apply to your out-of-pocket limit.

Copayments are flat-dollar amounts you must pay for most prescriptions after your deductible is met until the out-of-pocket maximum is reached.

Coinsurance

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Coinsurance is not applied to in-network services.	The out-of-network deductible must be met first. Then 20% coinsurance applies to out-of-network services and 25% for pharmacy. Most Michigan pharmacies are in-network. For drugs obtained from an out-of-network pharmacy, see the section on Prescription Drugs .	The out-of-network deductible must be met first. Then 20% coinsurance applies. Non-participating providers may also bill you for fees above the approved amount. These fees are not covered by your plan, nor do they apply to your out-of-pocket limit.

Coinsurance is a percentage of the charges for services received for which you are financially responsible. After you have met your deductible, you are responsible for prescription drug copayments, coinsurance for out-of-network services and in-network private duty nursing services.

NOTE: You pay 10% of the charges for private duty nursing.

MESSA Health Resources

Tools to help you stay healthy

At MESSA we know that good health matters to you. Our Member Education Department works to promote healthy living and good health practices. MESSA sponsors annual Wellness Conferences around the state for school employees, produces brochures on healthy living and publishes a monthly newsletter through the Mayo Clinic.

MESSA Member Education - 800.336.0022

- ▶ **Asthma Management Program**
- ▶ **Cardiovascular Health Education Program**
- ▶ **Diabetes Education Program**

Health education programs that succeed in getting people to make healthier lifestyle choices are proving to be wise, cost-effective strategies that can dramatically lower out-of-pocket health care costs over time. Studies show that people with chronic illnesses enrolled in health education programs have fewer hospital admissions, fewer emergency room visits and lower overall medical costs.

Members can call MESSA Member Education at 800.336.0022 to get additional information on these programs. On the web, go to www.messa.org and choose Health Resources on the top menu bar for additional information.

MESSA Support Programs

- ▶ **Medical Case Management – 800.441.4626**

Experiencing a catastrophic illness or injury can be a challenging, life-changing event for a patient and their family. That is why MESSA offers Medical Case Management (MCM), a unique program tailored to meet the medical needs of our members needing extraordinary care. MCM offers the support of a Nurse Case Manager who will assist the patient and family with important treatment decisions. If you have questions regarding MCM, please contact the MESSA Health Care Resources department at 800.441.4626.

- ▶ **NurseLine – 800.414.2014**

Speak to a registered nurse 24/7 at MESSA NurseLine, a health information phone line staffed around the clock by registered nurses trained to answer medical questions and offer guidance. NurseLine may help you avoid

unnecessary emergency room visits and other health care expenses and will help you feel confident about the health care decisions you make. The NurseLine number is 800.414.2014. Program it into your cell phone now so that health information is only a phone call away.

▶ **Healthy Expectations – 800.336.0013**

MESSA's Healthy Expectations program provides support for expectant mothers. When you enroll in Healthy Expectations, you will receive a simple health assessment questionnaire to complete and return. If any risk factors are identified, a MESSA nurse may contact you and offer additional assistance. Women who enroll receive a reference book on pregnancy and birth and a second book containing health guidelines to help you care for your baby, plus a baby bag that contains a bottle, bib, and blanket— all made in the USA. Enroll today by calling 800.336.0013.

Alphabetical Listing of Specific Covered Services:

Acupuncture

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

We pay for acupuncture treatment with an approved diagnosis when performed by an M.D. or D.O. in an inpatient or outpatient hospital setting, ambulatory surgery facility or physician's office.

Allergy Services

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

We pay for the following allergy testing and therapy services performed by, or under the supervision of, a physician:

- ▶ Survey, including history, physical exam, and diagnostic laboratory studies
- ▶ Intradermal, scratch and puncture tests
- ▶ Patch, photo, insufflate, and provocative antigen tests
- ▶ Procedures to desensitize patients to antigens or haptens
- ▶ Ultrasound, radiotherapy and radiothermy treatments
- ▶ Injections of anti-allergen, antihistamine, bronchodilator or antispasmodic agents

We do not pay for: fungal or bacterial skin tests (such as those given for tuberculosis or diphtheria) or environmental studies, evaluation or control.

Ambulance

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	Annual in-network deductible (There is currently no network – In-network benefits apply)	Annual in-network deductible, plus charges in excess of the approved amount

Covered services include transportation by professional ambulance to, or from, the nearest hospital equipped to furnish treatment. Within the United States and Canada, benefits are also available for emergency transportation by air ambulance to the nearest hospital equipped to furnish treatment. In all cases, only the patient’s transportation is covered. Ambulance transportation is not covered for patient or family convenience or for physician preference.

Anesthesia

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

Services for giving anesthesia to patients undergoing covered services are payable to either:

- ▶ A physician, other than the physician performing the service
- ▶ A physician who orders and supervises anesthetist services
- ▶ A certified registered nurse anesthetist (CRNA) in an:
 - Inpatient hospital setting
 - Outpatient hospital setting
 - Participating ambulatory surgery facility

CRNA services must be performed under the medical direction of a licensed physician or under the general supervision of a licensed physician responsible for anesthesiology services.

If the operating physician gives the anesthesia, the services are included in our payment for the surgery.

Autism Spectrum Disorders

Autism Spectrum Disorders (ASD) include Autistic Disorder, Asperger’s Disorder and Autism Pervasive Developmental Disorder Not Otherwise Specified.

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

Applied Behavior Analysis Services

Applied Behavior Analysis (ABA) is an evidence-based treatment for ASD that is covered under this plan. ABA services are available for children through the age of 18. There is a maximum of 25 hours per week of line therapy.

Prior authorization of ABA services is required. If prior authorization is not obtained, the member will be responsible for 100% of the cost of treatment. A member seeking ABA services is required to go to a BCBSM-Approved Autism Evaluation Center (AAEC) for the evaluation, diagnosis and/or confirmation of a diagnosis of an ASD and have a high level treatment plan developed. If ABA services are recommended by the AAEC, the member can seek services from a Board-Certified Behavior Analyst (BCBA), who will then develop a detailed treatment plan specific to ABA treatment. The BCBA **must** obtain prior approval from BCBSM, otherwise the member will be responsible for the cost of treatment.

To be covered, ABA services must be provided or supervised by:

- ▶ A Board-Certified Behavior Analyst registered with BCBSM (all BCBA's registered with BCBSM are considered in-network), or
- ▶ A fully licensed psychologist, so long as the services performed are commensurate with the psychologist's formal university training and supervised experience

Additional Covered Services

Additional covered services for ASD (not included in the 25 hours of weekly line therapy) include:

- ▶ Physical Therapy (PT)
- ▶ Occupational Therapy (OT)
- ▶ Speech Therapy (ST)
- ▶ Other medical services used to diagnose and treat autism, including nutrition counseling and genetic testing as recommended by the treatment plan.

Services and Conditions Not Covered

- ▶ Conditions such as Rett's Disorder and Childhood Disintegrative Disorder
- ▶ Any treatment that is not a covered benefit by us, including, but not limited to, sensory integration therapy and chelation therapy

Definitions for autism-related services can be found in the [Glossary of Health Care Terms](#) of this booklet.

Bone Marrow Transplants – see [Appendices A and B](#)

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	Not covered

Services must be rendered in a participating facility.

When medically necessary, and not experimental or investigational, we pay for services for and related to:

- ▶ Allogeneic transplants
- ▶ Autologous transplants

We pay for a maximum of two transplants per member per condition to treat the covered conditions. [Click here](#) for the current list of covered conditions. You may also call MESSA Hospital Admissions at 800.336.0022 for information.

We will pay for services related to, or for high-dose chemotherapy, total body irradiation, and allogeneic or autologous transplants to treat conditions that are not experimental. We cover antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

Certified Nurse Midwife Services – (See [Maternity Care](#))

Chemotherapy

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

We pay for chemotherapeutic drugs that are:

- ▶ Ordered by a physician for the treatment of a specific type of malignant disease
- ▶ Provided as part of a chemotherapy program
- ▶ Approved by the Food and Drug Administration for use in chemotherapy

NOTE: If the FDA has not approved the drug for the specific disease being treated, MESSA and BCBSM’s Medical Policy departments determine the appropriateness of the drug for that disease by using the following criteria:

- ▶ Current medical literature must confirm that the drug is effective for the disease being treated.
- ▶ Recognized oncology organizations must generally accept the drug as treatment for the specific disease.
- ▶ The physician must obtain informed consent from the patient for the treatment.

We also pay for:

- ▶ Physician services for the administration of the chemotherapy drug, except those taken orally
- ▶ The chemotherapy drug administered in a medically approved manner
- ▶ Other FDA-approved drugs classified as:
 - Anti-emetic drugs used to combat the toxic effects of chemotherapeutic drugs
 - Drugs used to enhance chemotherapeutic drugs
- ▶ Drugs to prevent or treat the side effects of chemotherapy treatment
- ▶ Administration sets, refills and maintenance of implantable or portable pumps and ports

Chiropractic Services – 38 visit maximum per calendar year

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

We pay for spinal manipulation to treat misaligned or displaced vertebrae of the spine. Other services such as traction, custom orthotics and certain modalities are also covered. We also pay for X-rays when the diagnosis is an incomplete or partial dislocation in the spinal area. Benefits are provided for a combined in- and out-of-network maximum of 38 visits per member per calendar year. There are some medical services provided by in-network and participating providers, covered by MESSA, that are not BCBSM benefits. For these services, providers may require you to pay charges in excess of our approved amount.

Colonoscopy – (See [Preventive Care Services](#))

We pay for one screening colonoscopy per member per calendar year. Subsequent medically necessary colonoscopies are subject to your deductible and coinsurance.

Consultations

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

We pay for inpatient and outpatient consultations when your physician requires assistance in diagnosing or treating your condition. The assistance is required because of the special skill and knowledge of the consulting physician or professional provider.

Cosmetic Surgery

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

Cosmetic surgery is payable only for:

- ▶ Correction of deformities present at birth (congenital deformities of the teeth are not covered)
- ▶ Correction of deformities resulting from cancer surgery, including reconstructive surgery after a mastectomy
- ▶ Conditions caused by accidental injuries
- ▶ Traumatic scars

NOTE: Services for cosmetic surgery are not payable when services are primarily performed to improve appearance.

Dental Services

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	Annual in-network deductible (There is currently a very limited network – in-network benefits apply)	Annual in-network deductible, plus charges in excess of the approved amount

Covered services include dental treatment by a licensed dentist or dental surgeon required for:

- ▶ Accidental injury to sound natural teeth
- ▶ Removal of cysts and tumors of the mouth and jaw
- ▶ Extraction of impacted teeth

Restrictions

- ▶ Dental surgery is payable only for:
 - Multiple extractions or removal of unerupted teeth, alveoplasty or gingivectomy performed in a hospital when the patient has an existing concurrent hazardous medical condition
 - Surgery on the jaw joint
 - Arthrocentesis performed for the reversible or irreversible treatment of jaw joint disorder

For non-covered services, please see the [Exclusions and Limitations](#) section of this booklet.

Diagnostic Services

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

We pay for physician services to diagnose disease, illness, pregnancy or injury through such tests as:

- ▶ Thyroid function
- ▶ Electrocardiogram
- ▶ Electroencephalogram
- ▶ Electromyogram
- ▶ Nerve conduction
- ▶ Pulmonary function studies

The services must be prescribed by a payable provider.

Diagnostic Laboratory and Pathology Services

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

We pay for laboratory and pathology exams needed to diagnose a disease, illness, pregnancy or injury. The services must be prescribed by a physician and may be performed at a physician’s office, hospital, or sent to a laboratory.

NOTE: If the physician has a laboratory perform these services, it must be an in-network laboratory for you to receive in-network benefits. You will be required to pay the out-of-network deductible and coinsurance when services are provided by an out-of-network laboratory unless your in-network physician refers you to an out-of-network laboratory for tests.

Durable Medical Equipment (DME)

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	Annual in-network deductible (There is currently no network – in-network benefits apply)	Annual in-network deductible, plus charges in excess of the approved amount

Covered services include the rental cost, not to exceed the purchase price, of durable medical equipment when prescribed by a physician and purchased from a recognized DME provider. Call MESSA for more information. Benefits include items such as hospital beds and wheelchairs. Items such as air purifiers, whirlpools, air conditioners and exercise equipment are not covered.

Emergency Room or Urgent Care (Medical Emergencies)

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	Annual in-network deductible	Annual in-network deductible, plus charges in excess of the approved amount (for professional charges only)

A Medical Emergency is defined as follows: “A condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately.”

We pay for facility services and physician services for the initial exam and treatment of a medical emergency or an accidental injury in the outpatient department of a hospital or an urgent care center, after the annual deductible has been satisfied.

Emergency Room or Urgent Care (Non-Emergency Care)

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

Non-emergency treatment at ER or urgent care: We pay for facility and physician services for the initial exam and treatment in the outpatient department of a hospital or urgent care center.

However, if the treatment is for a diagnosis that is not considered to be a “medical emergency” or the patient is not admitted to the hospital, or the treatment is not for an accidental injury, additional charges may apply for professional services provided.

End Stage Renal Disease (ESRD)

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

If you are diagnosed with End Stage Renal Disease you should contact your HSA administrator to discuss how Medicare will impact your HSA account.

Physician services are payable for the treatment of ESRD. Services may be provided in the hospital, a freestanding facility (designated by BCBSM to provide such services) or in the home.

NOTE: Physician services for the treatment of ESRD are covered in coordination with Medicare. It is important that individuals with ESRD apply for Medicare Part B coverage through the Social Security Administration. MESSA is the primary payer to Medicare for up to 33 months (this includes the three-month waiting period from the time the member is diagnosed with ESRD), if the member is under age 65 and eligible for Medicare because of ESRD.

NOTE: Call your local Social Security Administration or visit www.medicare.gov for assistance with enrollment. You may also call MESSA Member Services at 800.336.0013 with questions about your benefits.

Hearing Care

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

Hearing-related services performed by an M.D. or D.O are covered under the standard medical care benefit portion of your plan.

Audiology Services

What YOU Pay for Covered Services
In-network benefits apply – There is currently no network
Annual in-network deductible, plus charges in excess of the approved amount

We pay for covered services performed by an audiologist who is licensed or legally qualified to perform these services.

Covered expenses include:

- ▶ An audiometric examination for either ear, or both ears, that:
 - Is prescribed by a physician-specialist
 - Is performed by a physician-specialist, audiologist or hearing aid specialist or dealer

- Is performed within six months of a medical hearing loss examination by a physician-specialist
- Includes tests for measuring hearing perception relating to air conduction, bone conduction, speech reception threshold, and speech discrimination
- Includes a summary of findings

Hearing Aids

What YOU Pay for Covered Services	
In-network benefits apply – There is currently no network	
Annual in-network deductible, plus charges in excess of the approved amount (see below)	

There is a maximum benefit, adjusted annually based on the Consumer Price Index (CPI), for a hearing aid for each ear during a 36-month period. In addition, an audiometric examination, a hearing aid evaluation, and a conformity test for each ear will be paid during a 36-month period.

- ▶ The hearing aid(s) must be:

 - Designed to be worn in the ear, behind the ear or on the body
 - Prescribed by a physician-specialist, audiologist, or hearing aid specialist or dealer based on the most recent audiometric examination and hearing aid evaluation test
 - The make and model prescribed by the physician-specialist, audiologist, or hearing aid specialist or dealer; and
 - Provided by a hearing aid specialist or dealer
- ▶ Coverage includes a hearing aid evaluation test and a conformity test for either ear, or both ears, that is:

 - Prescribed by a physician-specialist
 - Performed following a medical hearing loss examination and an audiometric examination
 - Performed by a physician-specialist or audiologist or hearing aid specialist or dealer

Hemodialysis

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

Services are payable when provided in the hospital outpatient department, freestanding facility or in a home hemodialysis program.

Home Health Care

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	Annual in-network deductible (There is currently no network – In-network benefits apply)	Annual in-network deductible, plus charges in excess of the approved amount

This program provides an alternative to long-term hospital care by offering coverage for care and services in the patient’s home. Services must be prescribed by the patient’s attending physician, be medically necessary and be provided by a home health care agency.

To qualify for this benefit, a covered person must have physician certification assuring home health care is a medically necessary alternative to hospital confinement. The services are available based on a 30-day benefit period. The benefit period may be renewed with certification from the physician. Covered services include:

- ▶ Part-time skilled nursing care (full-time care is not covered) rendered by a registered nurse or a licensed practical nurse
- ▶ Medical care rendered by a home health aide or nurses’ assistant under the direct supervision of a registered nurse
- ▶ Medical supplies other than drugs and medicines requiring a written prescription from a physician
- ▶ Rental of medical equipment (not to exceed purchase price)
- ▶ Physical therapy, occupational therapy, speech therapy, social service guidance, and nutritional guidance provided by a home health care agency
- ▶ Hospital services and supplies related to the injury or illness which required or would have required the hospital confinement and would normally be provided by the hospital

NOTE: Meals, general housekeeping services and custodial care are not covered.

Hospice Care

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	Annual in-network deductible (There is currently no network – in-network benefits apply)	Annual in-network deductible, plus charges in excess of the approved amount

Hospice benefits allow covered terminally ill patients to spend their final days at home or in a special hospice facility as approved by us. You may apply for hospice benefits after discussion with, and with a referral by, the attending physician.

Benefits become available when:

- ▶ The covered patient is terminally ill with a life expectancy of 12 months or less as certified in writing by the attending physician or
- ▶ You are a covered dependent of the terminally ill patient meeting the requirements described above. Hospice care services are payable for four 90-day periods. The following criteria must be met:
 - The patient or his or her representative elects hospice care services in writing. This written statement must be filed with a participating hospice program.
 - The following certifications are submitted to us:

First 90-day period

- ▶ A written certification stating that the patient is terminally ill, signed by the:
 - Medical director of the hospice program **or** physician of the hospice interdisciplinary group and attending physician, if the patient has one

Second 90-day period (Submitted no later than two days after this 90-day period begins):

- ▶ The hospice must submit a second written certification of terminal illness signed by the:
 - Medical director of the hospice **or** physician of the hospice interdisciplinary group

Third 90-day period *(Submitted no later than two days after this 90-day period begins):*

- ▶ The hospice must submit a third written certification of terminal illness signed by the: medical director of the hospice **or** physician of the hospice interdisciplinary group

Fourth 90-day period *(Submitted no later than two days after this 90-day period begins):*

- ▶ The hospice must submit a fourth written certification of terminal illness signed by the: medical director of the hospice **or** physician of the hospice interdisciplinary group

The patient, or his or her representative, must sign a “Waiver of Benefits” form acknowledging that the patient has been given a full explanation of hospice care. This waiver confirms the patient’s (or family’s) understanding that regular benefits for conditions related to the terminal illness are not in force while hospice benefits are being used.

NOTE: Our benefits for conditions **not** related to the terminal illness remain in effect.

Payable services

Services for the patient will be paid up to an annual maximum that is reviewed and adjusted periodically (call MESSA for information about the current maximum amount).

Before electing to use hospice care services, the patient and his or her family are eligible to receive counseling, evaluation, education and support services from the hospice staff. These services are limited to a 28-visit maximum.

When a patient elects to use hospice care services, regular MESSA coverage for services in connection with the terminal illness and related conditions are replaced with the following:

- ▶ Inpatient care provided by a hospice inpatient unit, hospital or skilled nursing facility contracting with the hospice program
- ▶ Occasional respite care of up to five days duration, within a 30 calendar day period, to relieve family members or other persons caring for the member at home
- ▶ Part-time skilled nursing care (full-time care is not included) by a registered nurse or licensed practical nurse
- ▶ Medical supplies
- ▶ Rental of medical equipment (not to exceed purchase price)
- ▶ Physical therapy, emotional support services, homemaker or home health aide services (provided by or on behalf of the hospice program)
- ▶ Charges for physician services
- ▶ Bereavement counseling for the family after the patient’s death. This bereavement counseling benefit ends:
 - 12 months after the date of the first family unit counseling session
 - 18 months after the date the hospice benefit began or
 - Upon payment of the maximum hospice benefit payment, whichever occurs first

Hospital Care

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

Coverage is available for:

- ▶ Inpatient hospital services
- ▶ Outpatient hospital facility services
- ▶ Human organ transplants
- ▶ Bone marrow transplants
- ▶ Freestanding ambulatory surgery facility services*
- ▶ Home health care services
- ▶ Hospice services
- ▶ Skilled nursing facility services

All services must be prescribed by your physician and be determined to be medically necessary.

**There is currently no network for freestanding ambulatory surgery facilities. Benefits will be paid at the in-network level. However, if the facility does not participate with BCBSM, you may be responsible for charges in excess of the approved amount which may be substantial.*

Human Organ Transplants

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible — in BCBSM-designated facility only	Not covered	Not covered

Preapproval

Services for specified organ transplants performed during the transplant benefit period are paid at 100 percent of the approved amount when prior approval has been obtained from us in accordance with our criteria. Services must be received at a designated facility. If your condition or proposed treatment plan changes after preapproval is granted, your provider must submit a new request for preapproval. Failure to do so will result in the transplant and all related services not being covered.

When performed in a designated facility, we pay for transplantation of the following organs:

- ▶ Combined small intestine-liver
- ▶ Heart
- ▶ Heart/lung(s)
- ▶ Liver
- ▶ Lobar lung
- ▶ Lung(s)
- ▶ Pancreas
- ▶ Partial liver
- ▶ Kidney-liver
- ▶ Simultaneous pancreas-kidney
- ▶ Small intestine (small bowel)
- ▶ Multivisceral transplants (as determined by us)

Benefit period

All payable human organ transplant services, except anti-rejection drugs, must be provided during the benefit period that begins five days before, and ends one year after, the organ transplant.

Other transplant-related coverage

When directly related to the transplant, we pay for:

- ▶ Facility and professional services
- ▶ Anti-rejection drugs and other transplant-related prescription drugs, as needed. Payment will be based on BCBSM's approved amount.
- ▶ Immunizations against certain common infectious diseases during the first 24 months post-transplant are covered. We pay for immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP). This also includes kidney transplants, but not cornea or skin.
- ▶ Medically necessary services needed to treat a condition arising out of the organ transplant surgery if the condition:
 - Occurs during the benefit period, and
 - Is a direct result of the organ transplant surgery.

NOTE: We will pay for any service needed to treat a condition as a **direct** result of the organ transplant surgery, if it is a benefit under this plan.

Travel costs and organ acquisition

We also pay for the following:

- ▶ Up to \$10,000 for eligible travel and lodging during the initial transplant surgery. This includes:
 - Cost of transportation to and from the designated transplant facility for the patient and another person eligible to accompany the patient (two persons if the patient is a child under the age of 18 or if the transplant involves a living related donor).
 - In certain limited cases, we may consider return travel needed for an acute rejection episode to the original transplant facility. The cost of the travel must still fall under the \$10,000 maximum for travel and lodging and occur within the benefit period.
 - Reasonable and necessary costs of lodging for the person(s) eligible to accompany the patient ("lodging" refers to a hotel or motel)
- ▶ Cost of acquiring the organ (the organ recipient must be a MESSA member). This includes but is not limited to:
 - Surgery to obtain the organ
 - Storage of the organ
 - Transportation of the organ
- ▶ Living donor transplants such as partial liver, lobar lung, small bowel and kidney transplants that are part of a simultaneous kidney transplant
- ▶ Payment for covered services for a donor if the donor does not have transplant services under any health care plan

NOTE: We will pay the BCBSM approved amount for the cost of acquiring the organ.

Exclusions and Limitations

We do not pay for the following for specified organ transplants:

- ▶ Services that are not benefits under this plan
- ▶ Services rendered to a recipient who is not a MESSA member

- ▶ Living donor transplants not listed herein
- ▶ Anti-rejection drugs that do not have FDA approval
- ▶ Transplant surgery and related services performed in a non-designated facility. You must pay for the transplant surgery and related services you receive in a non-designated facility unless medically necessary and approved by the BCBSM/MESSA medical director
- ▶ Transportation and lodging costs for circumstances other than those related to the initial transplant surgery and hospitalization
- ▶ Items that are not considered directly related to travel and lodging (examples include, but are not limited to the following: mortgage, rent payments, furniture rental, dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, cash advances, lost wages, tips, toys, household products, alcoholic beverages, flowers, greeting cards, stationery, stamps, gifts, household utilities (including cell phones), maids, babysitters or daycare services, services provided by family members, reimbursement of food stamps, mail/UPS services, internet service, and entertainment (such as cable television, books, magazines and movie rentals)
- ▶ Routine storage cost of donor organs for the future purpose of transplantation
- ▶ Services prior to your organ transplant surgery, such as expenses for evaluation and testing, unless covered elsewhere in your plan
- ▶ Experimental transplant procedures

Human Organ Transplants (Kidney, Cornea and Skin)

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

Services for kidney, cornea and skin transplants are covered as standard benefits and do not require preapproval and are not limited to specific transplant facilities. We provide coverage for routine services for an eligible member, the donor, and tissue typing of the potential donor. You are also covered for the costs incurred in connection with acquisition and transportation of the organ.

Mammography

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
No deductible — 100% covered	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

We pay for one preventive mammography per member per calendar year.

Maternity Care

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Pre-natal care is covered at 100% Annual in-network deductible applies to delivery	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

You have coverage for prenatal care office visits and obstetrical services including delivery. Maternity care benefits also are payable when provided by a certified nurse midwife.

Medical Case Management (MCM)

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

This is a benefit designed to assist you if you are diagnosed with a catastrophic illness or injury. It is tailored to meet your unique medical needs. Approval of benefits will be based on an objective review of your medical status, current treatment plan, projected treatment plan, long-term cost implications and the effectiveness of care.

Eligibility for MCM benefits and termination of such benefits is made on a case-by-case basis in accordance with medically necessary criteria. The following medical conditions are examples of what may be considered for MCM:

- ▶ Pancreatitis
- ▶ Major head trauma
- ▶ Spinal cord injury
- ▶ Amputations
- ▶ Multiple fractures
- ▶ Severe burns
- ▶ Neonatal high-risk infants
- ▶ Severe stroke
- ▶ Multiple sclerosis
- ▶ Amyotrophic lateral sclerosis (Lou Gehrig’s disease)
- ▶ Acquired immune deficiency syndrome (AIDS)
- ▶ Crohn’s disease
- ▶ Cancer

Medical Case Management is designed to give you and your family members flexibility and direct involvement in the management of your health care.

NOTE: Prior approval must be obtained from MESSA before benefits can begin. If you have any questions regarding MCM, please contact MESSA at 800.441.4626

Medical Supplies

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	Annual in-network deductible (There is currently no network — in-network benefits apply)	Annual in-network deductible, plus charges in excess of the approved amount

We pay for medical supplies and dressings to be used in your home for the treatment of a specific medical condition.

Mental Health and Substance Abuse Services

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

We pay for mental health and substance abuse services that are medically necessary and provided by an eligible provider.

Eligible providers:

- ▶ Medical doctors (M.D.)
- ▶ Doctors of osteopathy (D.O.)
- ▶ Fully licensed psychologists (Ph.D., D.Psy., F.L.P.)
- ▶ Clinical Licensed Master’s Social Worker (CLMSW)
- ▶ Certified nurse practitioners (C.N.P.)*
- ▶ Hospital-based mental health facilities*
- ▶ Outpatient psychiatric care facilities*
- ▶ Hospital-based and freestanding residential substance abuse facilities*
- ▶ Outpatient substance abuse treatment programs*

**For coverage regarding services rendered by a non-participating provider, contact MESSA for more information.*

NOTE: For Michigan MSWs who are members of the Academy of Certified Social Workers (ACSW), contact MESSA for coverage information.

Newborn Examination

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

A newborn’s first routine physical exam is payable* when provided during the inpatient hospital stay. The exam must be provided by a doctor other than the anesthesiologist or the attending physician.

NOTE: MESSA must receive notification from your School Business Office within 30 days of the newborn's birth to add the newborn to your plan. Contact MESSA for additional information.

Nutritional Counseling

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

Some Nutritional Counseling is considered Preventive Care under Health Care Reform. For these conditions, there is no deductible and only in-network physician services are covered as well as those provided by a Registered Dietician. Calendar year visit limits apply. For more information, see [Preventive Care](#).

Nutritional Counseling is also available for specific medical conditions. The deductible and coinsurance apply. There are lifetime visit limits for these services.

Please call MESSA Member Services prior to receiving counseling in order to determine your benefits.

Obstetrics – (See [Maternity Care](#))

Occupational Therapy – (See [Therapy Services](#))

Office, Outpatient, Home Physician Visits and Consultations

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

We pay for medically necessary services for office, outpatient and home medical care visits and consultations when rendered by a payable provider.

We do not pay for routine eye refractions and audiometric tests, except in connection with a medical diagnosis, pregnancy, or injury.

Oncology Clinical Trials*

What YOU Pay for Covered Services
Annual in-network deductible – Services must be received at a Designated Cancer Center or Affiliate Cancer Center to be covered

***Preapproval is mandatory.** We will not pay for services, admissions or lengths of stay that are not preapproved. Approvals are in effect for one year. However, preapproved services, admissions or a length of stay will not be paid if you no longer have coverage at the time they occur. If one or more in-network or participating BCBSM providers participate in an approved clinical trial, we may require members to participate in the trial through one of those providers unless the trial is conducted outside of Michigan.

We cover specified bone marrow and peripheral blood stem cell transplants, their related services and FDA-approved antineoplastic drugs to treat stages II, III and IV breast cancer and all stages of ovarian cancer when they are provided pursuant to an approved phase II or III clinical trial. Coverage of antineoplastic drugs is not limited or precluded when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

Immunizations against certain common infectious diseases during the first 24 months post-transplant are covered. We pay for immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP).

Travel and Lodging

We will pay up to a total of \$5,000 for travel and lodging expenses directly related to preapproved services rendered during an approved clinical trial. The expenses must be incurred during the period that begins with the date of preapproval and ends 180 days after the transplant. However, these expenses will not be paid if your coverage is no longer in effect.

We will pay the expenses of an adult patient and another person, or expenses of a patient under the age of 18 and expenses for two additional people. The following per day amounts apply to the combined expenses of the patient and persons eligible to accompany the patient:

- ▶ \$60 per day for travel
- ▶ \$50 per day for lodging

NOTE: These daily allowances may be adjusted periodically. Please contact MESSA for the current maximums allowed.

Routine Patient Costs

We cover the routine costs of items and services related to Phase I, II, III or IV clinical trials whose purpose is to prevent, detect or treat cancer or other life-threatening disease or condition. The member receiving the items or services must be a qualified individual as defined herein.

We pay for all items and services related to an approved clinical trial if they are covered under this plan for members who are not participants in an approved clinical trial.

We do not pay for:

- ▶ The experimental or investigational item, device or service itself
- ▶ Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the trial participant, or
- ▶ A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Physical Therapy – (See [Therapy Services](#))

Prescription Drugs – Please refer to [Appendix C](#) for full details

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible plus Rx copayments up to the annual out-of-pocket maximum	25% coinsurance after annual out-of-network deductible, minus applicable copayment	25% coinsurance after annual out-of-network deductible, minus applicable copayment

[MESSA ABC free preventive drug list](#) Certain preventive medications used to treat chronic conditions, others mandated by federal law and birth control drugs, devices, implants and injections are covered 100% with no deductible required.

- ▶ You must pay 100% of the cost of other prescription drugs until the plan deductible is satisfied. **This is a requirement for HSA-qualified plans.**
- ▶ After the combined health and prescription drug deductible is met, prescription drug copayments will apply up to the annual out-of-pocket maximum:

In-network

- Deductible plus \$1,000 for single
- Deductible plus \$2,000 for 2-person and family

Out-of-network

- Deductible plus \$2,000 for single
- Deductible plus \$4,000 for 2-person and family

- ▶ Members will face additional cost if they insist on a brand-name drug when a less expensive generic is available. The additional costs do not apply to your annual deductible or out-of-pocket maximum.

Copayments (after the deductible)

- ▶ [\\$2 for specific preventive medications](#) in certain therapeutic classes used to treat specific chronic conditions. As of 7/1/12 the covered conditions are asthma and diabetes.
- ▶ \$10 for all other generic drugs
- ▶ \$10 for specific, Over-the-Counter (OTC) medications – for the treatment of seasonal allergies and heartburn – with a written prescription. As of 10/11 the covered OTC medications for the treatment of seasonal allergies are Allegra®, Allegra D®, Claritin®, Claritin D®, Zyrtec®, and Zyrtec D®. The covered OTC medications for the treatment of heartburn are Prevacid®, Prilosec®, and Zegerid®.
- ▶ \$20 (instead of \$40) for specific brand-name maintenance drugs prescribed to treat diabetes and asthma. As of 7/1/10 this includes insulin and glucagon emergency kits for diabetics and fast-acting or long-lasting inhalers and Zyflo® and Zyflo CR® for the treatment of asthma.
- ▶ \$40 for all other brand name drugs, including single-source drugs where no generic is available.

Note: If the approved amount is less than the copayment, you pay only the approved amount for the drug.

Preventive Care Services

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
No deductible — 100% covered	Not covered	Not covered

MESSA health plans include coverage for in-network preventive care services including one health maintenance exam per covered adult per calendar year; three preventive gynecological exams per calendar year; specific adult and child immunizations; and well-baby and child visits per the following schedule: six visits per year for children birth-35 months, two visits per year 36-47 months, one per calendar year thereafter.

The following links guide you to the current preventive care recommendations of the Affordable Care Act. For additional information, please contact your doctor or call MESSA Member Services at 800.336.0013.

[Preventive Care*](#) – List of covered screenings as recommended by the U.S. Preventive Care Services Task Force

[Pediatric Preventive Care](#) – Guidelines from the American Academy of Pediatrics and Bright Future

[Childhood Immunizations**](#) - Recommended Immunization Schedule for ages 0-6

[Childhood Immunizations**](#) - Recommended Immunization Schedule for ages 7-18

[Adult Immunizations**](#) - Recommended Adult Immunization Schedule

**Subsequent medically necessary colonoscopies and mammograms performed during the same calendar year are subject to applicable deductible and coinsurance.*

***Immunizations provided by a Public Health Department or at a MESSA-sponsored event are paid as in-network.*

NOTE: Except for mammograms and immunizations as noted above, Preventive Care Services are NOT covered out-of-network, even with a referral from an in-network provider.

Private Duty Nursing

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
10% after annual in-network deductible	10% coinsurance after annual out-of-network deductible	10% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

We pay for private duty nursing services in your home or in a hospital if it is:

- ▶ Skilled care given by a professional registered nurse or licensed practical nurse (requiring, for example: administration of I.V. drugs, ventilator care, etc.)
- ▶ Medically necessary and required on a 24-hour basis
- ▶ Given in a hospital, because the hospital lacks intensive or cardiac care units or has no space in such units
- ▶ Provided by a nurse who is not related to or living with the patient

All progress notes must be submitted with the claim form.

Prosthetic and Orthotic Devices

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	Annual in-network deductible (There is currently no network – in-network benefits apply)	Annual in-network deductible, plus charges in excess of the approved amount

Covered services include:

External appliances when they replace an absent part of the body or are intended to correct a defect of form or a function of the body. Appliances must be prescribed by a physician. Repairs or replacements are covered due to wear and tear or natural growth, unless otherwise specified. Benefits include, but are not limited to:

- ▶ External breast prostheses following a mastectomy.

These include three post-surgical brassieres each calendar year. Additional brassieres are covered if they are required because of:

- A significant change in body weight, or
- Hygienic reasons
- ▶ Wigs, when prescribed by a physician for hair loss for certain medical conditions
- ▶ Artificial eyes, ears, nose, larynx, limbs
- ▶ Eyeglasses and hearing aids when required because of an accidental injury sustained while covered by this plan

- ▶ Orthopedic shoes meeting guidelines established by us
- ▶ One pair of prescription eyeglasses or contact lenses when required because of:
 - Cataract surgery performed while covered by this plan
 - The absence of an organic lens
- ▶ Prefabricated custom-made orthotic appliances
- ▶ External cardiac pacemakers
- ▶ Maxillofacial prosthesis when approved; these devices may be provided by dentists

Radiology Services

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

Diagnostic – We pay for physician services to diagnose disease, illness, pregnancy or injury through:

- ▶ X-ray
- ▶ Ultrasound
- ▶ Radioactive Isotopes
- ▶ Computerized Axial Tomography
- ▶ Magnetic Resonance Imaging for specific diagnoses (call MESSA for information about any restrictions)
- ▶ Positron Emission Tomography (PET) scans (call MESSA for information about any restrictions)

Therapeutic – We pay for physician services to treat medical conditions by X-ray, radon, radium, external radiation or radioactive isotopes.

The services must be provided by the attending physician or another physician prescribed by the attending physician.

Skilled Nursing Care

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	Annual in-network deductible (There is currently no network – in-network benefits apply)	Annual in-network deductible, plus charges in excess of the approved amount

A skilled nursing facility provides comprehensive inpatient care of either a short or extended duration and is operated under the general direction of a licensed physician. This program provides benefits for skilled care in a skilled nursing facility only for the period that is necessary for the proper care and treatment of the patient, up to a maximum of 120 days per member, per calendar year. This benefit does not include custodial or domiciliary care.

Speech Therapy – (See [Therapy Services](#))

Surgical Services

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

Payment includes:

- ▶ Physician's surgical fee
- ▶ Pre- and post-surgery medical care provided by the surgeon while the patient is in the hospital
- ▶ Visits to the attending surgeon for the usual pre- and post-surgery care

Multiple surgeries

Multiple surgeries performed on the same day by the same physician are paid according to national standards recognized by us.

In-network and participating providers follow these guidelines and agree to accept our payment as payment in full. However, non-participating providers may bill you for the difference between the approved amount, less any required deductible, coinsurance, and billed charges.

Technical Surgical Assistance (TSA)

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

In some cases, an additional physician provides technical assistance to the surgeon. Certain procedures, when performed in a hospital inpatient or outpatient setting or in an ambulatory surgery facility, are identified as requiring TSA. A list of covered and approved TSA surgeries and additional information is available from MESSA.

We do not pay for TSA:

- ▶ When services of interns, residents or other physicians employed by the hospital are available at the time of surgery, or
- ▶ When services are provided in a location other than a hospital or ambulatory surgery facility

Therapy Services

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

The following therapy services are paid as indicated below if obtained in the outpatient department of a hospital, doctor's office, freestanding facility or by an independent physical therapist. Any therapy must be medically necessary and prescribed by a legally qualified physician except where noted.

Services are covered up to a **combined benefit maximum of 60 visits per member, per calendar year**, whether obtained from an in-network or out-of-network provider. All services provided in any outpatient location (hospital-based, freestanding facility or physician's office) are combined to meet the 60 visit maximum.

This benefit maximum renews each calendar year. We recommend that a course of treatment plan be submitted to MESSA before treatment begins.

Benefits include the following:

▶ Occupational therapy

Services must be performed by:

- A doctor of medicine or osteopathy
- An occupational therapist
- An occupational therapy assistant under the direct supervision of an occupational therapist
- An athletic trainer under the direct supervision of an occupational therapist

NOTE: Both the occupational therapist and the occupational therapy assistant must be certified by the National Board of Occupational Therapy Certification and registered or licensed in the state where the care is provided.

▶ Physical therapy

Services must be performed by:

- A doctor of medicine, osteopathy or podiatry
- A licensed physical therapist
- A physical therapy assistant under the general supervision of a licensed physical therapist
- An athletic trainer under the direct supervision of a licensed physical therapist

Therapy must be designed to improve or restore the patient's functional level when there has been a loss in musculoskeletal functioning due to an illness or injury.

▶ Speech therapy

Services must be performed by:

- A doctor of medicine or osteopathy
- A licensed speech-language pathologist

NOTE: We do not pay for services provided by speech-language pathology assistants or therapy aides.

For non-developmental conditions, treatment is available for both adults and children. For congenital and severe developmental conditions, treatment is available only for children.

The following therapy services are also covered when medically necessary if obtained in an outpatient department of a hospital, doctor's office or freestanding facility (unless otherwise stated):

▶ Chemotherapy

Services for malignancy include the cost of administration, physician services and drugs except when the treatment or drug is considered experimental or investigational.

▶ Radiation Therapy

Services for malignancy include X-rays, radium, external radiation or radioactive isotopes, except when the treatment is considered experimental or investigational.

▶ **Vision Therapy**

Services must be performed by a qualified orthoptist to correct defective visual habits. Benefits are not provided for the following:

- Learning disabilities
- Reading problems including dyslexia
- Reading or educational enhancement
- Non-accommodative strabismus, such as muscle paralysis

▶ **Hemodialysis**

Services are payable when provided in the hospital outpatient department, freestanding facility or in a home hemodialysis program.

Urgent Care – (See [Emergency Room](#))

Voluntary Sterilization for Men

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

Voluntary Sterilization for Women

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
No deductible – 100% covered	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

Weight Loss Treatment

What YOU Pay for Covered Services		
In-network	Out-of-network	Non-participating
Annual in-network deductible	20% coinsurance after annual out-of-network deductible	20% coinsurance after annual out-of-network deductible, plus charges in excess of the approved amount

We pay for services performed by a qualified physician for the treatment of morbid obesity. Call MESSA Member Services at 800.336.0013 for more information.

Well Baby/Well Child Care – (See [Preventive Care Services](#))

Your Medical Insurance ID Card

Your MESSA/BCBSM identification (ID) card is your key to receiving quality health care.

Your card will look similar to this:



Your medical insurance ID card is issued once you enroll for coverage. It lets you obtain services covered under MESSA. Only the enrollee's name appears on the medical insurance ID card. However, the cards are for use by all covered members and dependents.

The numbers on your personal medical insurance ID card will be different from the one illustrated above.

Line 1: Enrollee Name is the name of the person who holds the contract.

Line 2: Enrollee ID identifies your records in our files. The alpha prefix preceding the enrollee ID number identifies that you have coverage through MESSA.

Line 3: Issuer identifies you as a Blue Cross Blue Shield of Michigan member. The number 80840 identifies the industry as a health insurance carrier.

Line 4: Group Number tells us you are a MESSA group member. To the right of that is the date the card was issued.

The suitcase tells providers about your travel benefits. On the back of your medical insurance ID card, you will find:

- ▶ A magnetic strip which will help providers process your claims. It includes information from the front of the card and the enrollee's date of birth. It does not include any benefit or health information.
- ▶ MESSA's toll-free member services/inquiries telephone number to call us when you have a claim or benefit inquiry, as well as other important telephone numbers.

Here are some tips about your medical insurance ID card:

- ▶ Carry your card with you at all times to help avoid delays when you need medical attention.
- ▶ If you or anyone in your family needs a medical insurance ID card, please go to the secured area of www.messa.org and request one, or call the MESSA Member Service Center for assistance.
- ▶ Call the MESSA Member Service Center if your card is lost or stolen. You can still receive service by giving the provider your Enrollee ID number to verify your coverage.

Only you and your eligible dependents may use the cards issued for your plan. Lending your card to anyone not eligible to use it is illegal and subject to possible fraud investigation and termination of coverage.

Explanation of Benefit (EOB) Statements

You will receive an EOB form each time we process a claim under your enrollee ID/contract number. The EOB is not a bill. It is a statement that helps you understand how your benefits were paid.

Please check your EOBs carefully. If you see an error, please contact your provider first. If they cannot correct the error, call the MESSA Member Service Center.

If you think your provider is intentionally billing for services you did not receive or that someone is using your medical insurance ID card illegally, contact the anti-fraud toll-free hotline at 1.866.211.4475. Your call will be kept strictly confidential. By working together, we can help keep health care costs down.

NOTE: Go green! Stop the paper. You can sign up to receive electronic copies of your EOBs instead of paper. You can access the most current 24 months of EOBs in the member secured area of www.messa.org

Pre-Admission Review (PAR) Requirements

At in-network and participating hospitals, the hospital will take care of this requirement for you.

Non-participating hospitals

If you are using a non-participating hospital, then you, your doctor or hospital must request prior approval for all elective (nonemergency) admissions to a hospital.

- ▶ A completed PAR form must be sent to MESSA at least two weeks before the scheduled admission. The form may be downloaded from www.messa.org. Mail the completed form to MESSA at:

MESSA

Pre-Admission Review

1475 Kendale Blvd. P. O. Box 2560

East Lansing, MI 48826-2560 **OR**

- ▶ You, your doctor or hospital must call MESSA for a review of the admission request. The toll-free telephone number is 800.336.0022. MESSA will review your doctor's request and determine whether your admission will be authorized under our medically necessary criteria. MESSA will determine the number of days initially approved and will send written notice of the decision to you, your doctor and the hospital.

Emergency hospital admissions

Advance approval is not required for emergency admissions. However, your doctor or hospital must notify MESSA within 48 hours of the start of your admission, or within 72 hours of the start of the admission if it begins on a weekend (5 p.m. Friday through 9 a.m. Monday) or a holiday. MESSA will then determine the number of days to be authorized under our medically necessary criteria, and will provide written notice to you, your doctor and the hospital.

Requesting additional days

The hospital or your doctor can request additional days beyond the days initially approved. Whenever possible, such requests should be made up to 48 hours before the end of the days initially approved. MESSA will let you, your doctor and the hospital know if the request for additional days has been approved.

If the extension is not approved and your hospital admission exceeds the number of days determined by MESSA to be medically necessary, you will be responsible for the following:

- ▶ Charges for inpatient hospital room and board
- ▶ Other charges for medical services and supplies furnished by the hospital
- ▶ Physician charges for inpatient hospital visits
- ▶ Any other charges related to the days not approved

Requesting approval after admission

If the hospital or your physician fails to get approval before you are admitted, MESSA will still review a request, either while you are in the hospital or after your discharge. The disadvantage is that you will not know before the admission whether the care is covered.

Appealing a non-approved admission or extension

Your doctor may appeal all decisions by requesting a review by MESSA.

Receiving services without prior approval

If you were given prior notice of MESSA's denial of benefits before the admission began, or if you accepted such liability by entering into a prior agreement with your doctor, you will be responsible for all charges (both hospital and doctor) resulting from the admission.

How to File A Medical Claim

Non-participating providers may require you to pay for services at the time they are provided. To file your own claim, [use the form provided here](#), or follow these steps:

1. Ask the provider for an itemized statement with the following information:

- ▶ Patient's name and birth date
- ▶ Subscriber's name, address, phone number and contract number (from your medical insurance ID card)
- ▶ Provider's name, address, phone number and federal tax ID number
- ▶ Date, description, and charge for each service
- ▶ Diagnosis (nature of illness or injury) and procedure code
- ▶ Admission and discharge dates for hospitalization

2. Make a copy of all items for your files.

3. Mail the claim form and itemized statement to:

MESSA
1475 Kendale Blvd. P.O. Box 2560
East Lansing, MI 48826-2560

Please file claims promptly. There is a filing deadline.

Payment will be sent directly to you. The check will be in the enrollee's name, not the patient's name.

NOTE: If you or your dependent(s) have coverage through another carrier who is primary (see "Coordination of Benefits" in this section), please send your bill to MESSA along with a copy of the other carrier's explanation of benefits.

MESSA will send you an Explanation of Benefits (EOB) statement when a claim is processed. You can "go green" by choosing to receive these statements online. Two years of EOBs will be available online.

Care out of the country

We will only pay for services for emergency and unexpected illness for residents of the United States traveling in foreign countries. In addition, coverage applies only if:

- ▶ The hospital is accredited
- ▶ The physician is licensed

Most hospitals and doctors in foreign countries will ask you to pay the bill. Try to get itemized receipts, preferably written in English. When you submit your claim, tell us if the charges are in U.S. or foreign currency. Be sure to indicate whether payment should go to you or the provider. We will pay the approved amount for covered services at the rate of exchange in effect on the date you received your services, minus any deductibles or coinsurance that may apply.

Eligibility Guidelines

If you are a dependent under another medical plan you should consult your HSA administrator about the tax consequences for your HSA account. You should also contact your HSA administrator if a dependent (other than your spouse) is an adult.

Who is eligible for coverage?

The following individuals are eligible to become members of the Michigan Education Special Services Association (MESSA) and may apply for coverage:

- ▶ Any active, associate, service associate, retiree, or student member of the Michigan Education Association (MEA) as defined in the MEA bylaws
- ▶ Any member of a bargaining unit in an educational agency in which a local association of MEA is the recognized bargaining agent and has negotiated MESSA benefits for its members
- ▶ Any administrator employed by an educational agency in which a local association of the MEA is a recognized bargaining agent and has negotiated MESSA benefits for its members
- ▶ Any other eligible individual as defined in the MESSA bylaws

Applying for coverage

An application is required if you are:

- ▶ Enrolling for the first time
- ▶ Changing coverage for yourself or your dependents
- ▶ Changing school districts
- ▶ Covering dependent children age 19 or older

We will review your application for coverage to determine if you, your spouse and your dependents are eligible for coverage based on the terms of your plan.

If you, your group or someone applying for coverage on your behalf commits fraud or makes an intentional misrepresentation of material fact in completing the application, your coverage may be rescinded as stated in the section on [When coverage ends](#).

Eligible dependents

If you are covered, your eligible dependents include:

- ▶ Your spouse
- ▶ Your children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until a maximum of the end of the calendar year of their 26th birthday

NOTE: Your child's spouse and your grandchildren are not covered under this plan.

- ▶ Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are developmentally disabled or physically handicapped, dependent upon you for a majority of their support and who are incapable of self-sustaining employment by reason of their developmental disability or physical handicap. (Under no circumstances will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA to obtain the appropriate form to continue coverage.
- ▶ Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are full-time students and dependent on you for a majority of their support.
- ▶ We will continue coverage when the dependent student takes a leave of absence from school or changes to part-time status due to serious illness or injury. The continuation of coverage will last until the earlier of the following dates occurs:
 - Up to one year after the first day of a medically necessary leave of absence or change in status
 - The date on which the student's coverage would otherwise terminate
 - To qualify for continued coverage, the student's attending physician must certify in writing that the student suffers from a serious illness or injury and that the leave or change in status is medically necessary. The student must continue to meet all other MESSA eligibility requirements.
- ▶ Your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year and are continuing in that status for the current tax year. (Children, who are no longer eligible for coverage as dependent children, cannot be covered as sponsored dependents.)

You may also request group coverage for yourself or your dependents within 60 days of either of the following events:

- ▶ Your Medicaid coverage or your dependents' CHIP coverage (Children's Health Insurance Program) is terminated due to loss of eligibility.
- ▶ You or your dependent becomes eligible for premium subsidies.

It is your responsibility to notify MESSA and your employer:

- ▶ Of any change in your employment status
- ▶ When you wish to add a spouse and/or dependent(s)
- ▶ Of any change to a dependent's eligibility for coverage
- ▶ When a spouse and/or dependent is no longer eligible as defined above

Special health care coverage guidelines apply to you and your spouse at age 65 during your active school employment. You should contact your school business office or MESSA for complete details. The Social Security Administration should be contacted regarding Medicare enrollment 120 days prior to attaining age 65.

When coverage begins

The following information details the guidelines for your effective date of coverage:

- ▶ If you are a new employee and enroll for coverage within 31 days following the date you became eligible (your date of employment or the day following completion of the eligibility waiting period, whichever is later), your coverage will be effective on the date you became eligible. This date is verified by your employer.
- ▶ During open enrollment, the effective date of coverage for all new applications and coverage changes will be the date approved by MESSA and verified by your employer.
- ▶ If your application is submitted at any other time, your coverage will be effective on the first day of the month following approval of your application by MESSA.
- ▶ Each dependent will be eligible for coverage on the later of the date on which your coverage begins or the date he/she becomes an eligible dependent if enrolled within 31 days. If your application for dependent coverage is submitted at any other time, coverage will be effective on the first day of the month following approval of your application by MESSA.
- ▶ Each sponsored dependent will be eligible for coverage on the later of the date on which your coverage begins or the first day of January following the date he/she becomes an eligible dependent.

When coverage ends

MESSA ABC Plan benefits end on the first day of the calendar month in which a covered individual becomes age 65. On that date, you will be enrolled in the MESSA Limited Medicare Supplemental Plan. If, however, you continue active school employment and remain a MESSA member, your MESSA ABC coverage and that of your covered dependents will not end until the first of the following circumstances occurs:

- ▶ **Termination of employment** - Coverage will end on the last day of the month in which you terminate employment.
- ▶ **Nonpayment of contributions** - Coverage will end on the last day of the month preceding the month for which the required contribution has not been remitted to MESSA.
- ▶ **Termination of employer's participation** - Coverage will end on the last day of any month in which your employer ceases to participate under the MESSA BCBSM Group Agreement.
- ▶ **Rescission** – Coverage may be terminated back to the effective date of your coverage if you, your group, or someone seeking coverage on your behalf performed an act, practice, or omission that constitutes fraud, or has made an intentional misrepresentation of fact to us or another party which results in you or a dependent obtaining or retaining coverage with MESSA or the payment of claims under this or another MESSA plan. You will be provided with prior notice of the rescission, if required under the law. You will be required to repay us for our payment for any services you received during this period.
- ▶ **Member no longer eligible** - Coverage will end on the last day of the month in which a member no longer meets the eligibility criteria described in this section.
- ▶ **Dependent no longer eligible** - Coverage will end on the date a dependent no longer meets the eligibility criteria described in this section.

NOTE: An ex-spouse may be continued beyond the date of the divorce if the divorce decree stipulates that the member must provide health coverage for his/her ex-spouse. The member will be required to pay the sponsored dependent contribution in addition to his/her normal contribution. Coverage will terminate on either the date the ex-spouse remarries or the date which is 12 months following the date of the divorce, whichever is earlier.

- ▶ **Termination of the MESSA/BCBSM group agreement** - Coverage will end on the date the Group Agreement terminates.
- ▶ **Medicare elected as primary** - If you continue active school employment beyond age 65 and elect Medicare as your primary coverage, your coverage under MESSA ABC will end on the first day of the month following the date of your election. A spouse age 65 or older who obtains coverage through an active employee may also elect Medicare as his/her primary coverage; the spouse's coverage under MESSA ABC will end on the first day of the month following such an election.

NOTE: If you cease active work or leave school employment, inquire as to what arrangements, if any, may be made to continue coverage. Also see the following "Continuation of Health Care Coverage." Contact MESSA for additional information.

Continuation of health care coverage

Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA is a federal law that extends the opportunity for group coverage to members who no longer qualify as members of a group. For COBRA purposes, coverage includes the benefits described in this booklet. The continued coverage is available to covered employees, their spouses and dependent children (all of whom are referred to as "qualified beneficiaries") whose coverage would otherwise end upon the occurrence of a "qualifying event," the most common of which are listed below:

- ▶ The death of the covered employee
- ▶ The termination (other than by reason of gross misconduct) or reduction of hours of the covered employee's employment
- ▶ The divorce or legal separation of the covered employee
- ▶ A dependent child ceasing to be a dependent child under the generally applicable provisions of the program
- ▶ The covered employee becoming entitled to Medicare benefits. (Contact your HSA administrator for special rules.)

You and your dependent(s) must pay the required contribution, if any, for the continued coverage. Your employer will inform you of the monthly contribution to be paid.

In the event of your divorce or legal separation or if your dependent child ceases to be eligible as a dependent under the program, you or your dependent must notify the plan administrator (your employer) of the occurrence of the qualifying event within 60 days after it occurs or the date coverage is terminated, whichever is later.

Continued coverage must be elected within an election period that cannot end before the date which is 60 days after the later of (1) the date coverage is terminated and (2) the date you receive notice of the right to continue coverage.

The continued coverage, if elected, will begin on the date of the qualifying event and end when the first of the following events occurs:

- ▶ The date which is 36 months (18 months in the case of the termination or reduction in hours of the covered employee's employment) after the qualifying event

NOTE: You, or a covered dependent, may be able to extend continuation of coverage from 18 months to 29 months if the Social Security Administration has determined (or determines) that you, or a covered dependent, has been totally disabled since the date of eligibility for continuation coverage or within 60 days following that date. Continuation coverage may be extended only if the Social Security Administration makes its determination within 18 months of the qualifying event.

- ▶ The first day for which timely payment for the qualifying beneficiary is not made to the plan
- ▶ The date upon which your employer terminates participation under the MESSA/BCBSM Group Agreement that provides the benefits described in this booklet
- ▶ The date the qualified beneficiary becomes covered under any other group plan that is not maintained by your employer (other than a plan containing limitations or exclusions with respect to a pre-existing condition of the qualified beneficiary)
- ▶ The date the qualified beneficiary becomes entitled to benefits under Medicare

If during an established COBRA period of continuance, another qualifying event occurs that also entitles you or your dependent(s) to COBRA continuation, coverage may be extended, but not beyond the date which is 36 months from the date of the initial qualifying event.

If a qualified beneficiary's continued coverage ends due to the expiration of the 36-month, 29-month or 18-month maximum continuation period, the qualified beneficiary may enroll in any conversion health plan available. (See "Conversion Privilege," below.)

Your employer can provide you with more information concerning how these COBRA health plan continuation rights apply to you and your family members and how to elect continued coverage under the plan in the event of a qualifying event.

Conversion privilege

When you are no longer eligible for the MESSA ABC Plan through your employer, an individual health care plan is available to you through BCBSM. Your benefits will change and coverage will be limited to your immediate family.

There will be no interruption of coverage, provided you pay the premiums when due. To ensure continuous coverage you must apply within 31 days from the date your coverage terminates with your employer. Contact MESSA for additional information on how to apply for this coverage.

Surviving family

Your dependents who are covered under the MESSA ABC Plan on the date of your death should contact MESSA for information regarding continuation of coverage.

Exclusions and Limitations

The following exclusions and limitations apply to the MESSA ABC Plan. These are in addition to limitations appearing elsewhere in this booklet.

- ▶ Artificial insemination (including in vitro fertilization) and related services
- ▶ Treatment of work-related injuries covered by workers' compensation laws or for work-related services you receive through a medical clinic or a similar facility provided or maintained by your employer
- ▶ Charges toward your deductible or coinsurance requirements for in-network, out-of-network and non-participating providers that:
 - Exceed our approved amount
 - Are for non-covered services and limited covered services (i.e. accidental injuries and medical emergencies), or
 - Apply to deductibles, or coinsurance paid under other certificates

- ▶ Charges incurred because of war, declared or undeclared, or any act thereof; or for injury or sickness sustained or contracted in the armed forces or any country, or for services provided in a Veterans Administration Hospital for a covered person with military service-connected disability; or for services, supplies or treatments provided or covered under any governmental plan or law or which would have been furnished without costs in the absence of this coverage or for which the covered person has no legal obligation to pay. However, care and services are payable if federal laws require the government sponsored program to be secondary.
- ▶ Clerical fees including fees for patient records, custodial care or basic care that can be provided by someone other than a registered nurse or licensed practical nurse, and which is care provided primarily to assist the person in the activities of daily living
- ▶ Dental care (except as previously specified) including repairs of supporting structures for partial or complete dentures, dental implants, extractions, extraction repairs, bite splints, braces and appliances and other dental work or treatment
- ▶ Educational care and cognitive therapy
- ▶ Experimental treatment (including experimental drugs or devices) or services related to experimental treatment except as approved by the BCBSM or MESSA medical director. In addition, we do not pay for administrative costs related to experimental treatment or for research management.
- ▶ Eye examinations and eyeglasses or other corrective visual appliances except as specified elsewhere in this booklet
- ▶ Inpatient hospital confinement for the sole testing for, or detoxification of, allergy or allergy-related conditions
- ▶ Items for the personal comfort or convenience of the patient
- ▶ Reversal of sterilization procedures and related services
- ▶ Routine health examinations and related services or routine screening procedures (except as previously specified in the section on Preventive Care Services)
- ▶ Services, supplies, or treatment provided by an immediate relative or by anyone who customarily lives in the member's household
- ▶ Services and supplies that are not medically necessary according to the accepted standards of medical practice including any services which are experimental or investigational in nature

Because of ongoing medical research and technological advances, procedures that have been considered experimental may become generally accepted standard treatments. To be covered under this plan, these procedures must be recognized as a standard of care and be medically necessary for the illness or injury being treated.

- ▶ Conditions such as Rett's Disorder and Childhood Disintegrative Disorder
- ▶ Surgery for cosmetic or beautifying purposes (except as specified in the section on Cosmetic Surgery)
- ▶ Transplants (other than those previously specified) and all charges arising out of, or associated with, these transplants whether incurred prior to the transplant or subsequent to the transplant
- ▶ Transportation expenses (except as previously specified) including meals and lodging
- ▶ Health care services provided by persons who are not legally qualified or licensed to provide such services
- ▶ Anti-rejection drugs that do not have Food and Drug Administration (FDA) approval
- ▶ Conditions such as Rett's Disorder and Childhood Disintegrative Disorder
- ▶ Any treatment that is not a covered benefit by us, including, but not limited to, sensory integration therapy and chelation therapy

Grievance Process

We have a formal grievance and appeals process if you are unable to resolve your concerns through MESSA Member Services, or wish to contest an adverse benefit decision.

An adverse benefit determination is a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

If you choose to file a grievance or appeal:

- ▶ There is no cost to you to initiate a grievance or appeal. You may submit relevant written materials or written testimony to help us in our review at any step of the grievance or appeals process.
- ▶ You may authorize another person, including your physician, to act on your behalf at any stage in the standard internal grievance procedure. Your authorization needs to be in writing. Please call the customer service number on the back of your identification card and ask for a Designation of Authorized Representative and Release of Information form. Complete it and send it with your appeal.
- ▶ Although we have 35 days to give you our final determination, you have the right to allow us additional time if you wish.
- ▶ You may obtain copies of information relating to our denial, reduction or termination of coverage for a health care service free of charge.

The grievance and appeals process begins with an internal review by MESSA and BCBSM. Once you have exhausted your internal options, you have the right to a review by the Michigan Department of Insurance and Financial Services.

Standard Internal Grievance Process

STEP 1: You or your authorized representative must send us a written statement explaining why you disagree with our determination on your request for benefits or payment. Your request for review must be submitted within 180 days after receiving a notice of denial.

Mail your written grievance to:

Associate Manager, Legal and Compliance
MESSA
1475 Kendale Boulevard
P.O. Box 2560
East Lansing, MI 48826-2560

A decision will be made by MESSA/BCBSM after MESSA's receipt of request for review or the date all information required of you is furnished, whichever date is later. The decision will be in writing and will specify the reason for MESSA's/BCBSM's decisions.

STEP 2: If you are dissatisfied with this decision, you may request a Managerial-level Conference by mailing your written request to the same address as in STEP 1.

Once we receive your grievance, we will contact you to conduct or schedule a conference. That will be your opportunity to provide us with any additional information or testimony you want us to consider in reviewing your claim. You can ask that the conference be conducted in person or over the telephone. If in person, the conference can be held at BCBSM headquarters in Detroit, during regular business hours. Our written resolution will be our final determination regarding your grievance.

BCBSM and MESSA will complete both steps within 35 days of the date we receive your written grievance under Step 1. This 35-day period does not include the time between your receiving our decision under Step 1 and requesting further review under Step 2.

If you disagree with our final determination, or if we fail to provide it to you within 35 days of the date we received your initial grievance under Step 1, you may request an external review from the Michigan Department of Insurance and Financial Services.

Standard External Review Process

Once you have exhausted our standard internal grievance process, you or your authorized representative may request an external review from the Michigan Department of Insurance and Financial Services.

The standard external review process is as follows:

1. Within 60 days of the date you received our final determination, or should have received it, send a written request for an external review to the Director, Department of Insurance and Financial Services. Mail your request, including the required forms that we will supply to you, to:

Department of Insurance and Financial Services
Office of General Counsel
Health Care Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

2. If your request for external review concerns a medical issue and is otherwise found to be appropriate for external review, the Director will assign an independent review organization, consisting of independent clinical peer reviewers, to conduct the external review.
 - You will have an opportunity to provide additional information to the Director within seven days of submitting your request for an external review. We must provide documents and information considered in making our final determination to the independent review organization within seven business days after we receive notice of your request from the Director.
 - The assigned independent review organization will recommend within 14 days whether the Director should uphold or reverse our determination. The Director must decide within seven business days whether or not to accept the recommendation and will notify you. The Director's decision is the final administrative remedy under the Patient's Right to Independent Review Act of 2000.

If your request for external review is related to nonmedical issues and is otherwise found to be appropriate for external review, the Director's staff will conduct the external review.

The Director's staff will recommend whether the Director should uphold or reverse our determination. The Director will notify you of the decision, and the Director's decision is your final administrative remedy.

Expedited Internal Grievance

If a physician substantiates (either orally or in writing) that adhering to the timeframe for the standard internal grievance process would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, you may file a request for an expedited internal grievance.

You may file a request for an expedited internal grievance only when you think that we have wrongfully denied, terminated or reduced coverage for a health care service prior to your having received that health care service, or if you believe we have failed to respond in a timely manner to a request for benefits or payment.

The procedure is as follows:

1. You may submit your expedited internal grievance request by telephone to 800.742.2328, option 4. The required physician's substantiation that your condition qualifies for an expedited grievance can also be submitted by telephone.
2. We must provide you with our decision within 72 hours of receiving both your grievance and the physician's substantiation.

If you do not agree with our decision, you may, within 10 days of receiving it, request an expedited external review from the Michigan Department of Insurance and Financial Services.

Expedited External Grievance

If you have filed a request for an expedited internal grievance, you may request an expedited external review from the Michigan Department of Insurance and Financial Services.

You may file a request for an expedited external review only when you think that we have wrongfully denied, terminated or reduced coverage for a health care service prior to your having received that health care service.

The expedited external review process is as follows:

1. Within 10 days of your receipt of our denial, termination or reduction in coverage for a health care service, you or your authorized representative may request an expedited external review from the Director by calling 877.999.6442 to request the forms required.
2. Mail your request, including the required forms that we will give you, to:

Department of Insurance and Financial Services
Office of General Counsel
Health Care Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

Immediately after receiving your request, the Director will decide if it is appropriate for external review and assign an independent review organization to conduct the expedited external review. If the independent review organization decides that you do not have to first complete the expedited internal grievance procedure, it will review your request and recommend within 36 hours whether the Director should uphold or reverse our determination.

The Director must decide within 24 hours whether or not to accept the recommendation and will notify you. The Director's decision is the final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Pre-Service Appeals

For members who must get approval before obtaining certain health services.

The plan requires you to get approval before obtaining certain health services. If you disagree with our decision not to approve a service, you have the right to appeal it.

Please follow the steps below to request a review. If you have questions or need help with the appeal process, please call the MESSA member service number on the back of your identification card.

All appeals must be requested in writing. We must receive your written request within 180 days of the date you received notice that the service was not approved.

Requesting a Standard Review

You may make the request yourself, or your doctor or someone else acting on your behalf may make the request for you. If another person will represent you, that person must obtain written authorization to do so. Please call the customer service number on the back of your identification card and ask for a Designation of Authorized Representative and Release of Information form. Complete it and send it with your appeal.

Your letter requesting a review must include the following information:

- ▶ Your contract and group numbers, found on your MESSA insurance card
- ▶ A daytime phone number for both you and your representative
- ▶ The patient's name if different from the member
- ▶ A statement explaining why you disagree with our decision and any additional supporting information

Once we receive your appeal, we will provide you with our final decision within 30 days.

Requesting an Urgent Review

If your situation meets the definition of urgent under the law, your review will be conducted as soon as possible; generally within 72 hours. An urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an urgent review. You may also request a simultaneous external review.

For more information on how to request an urgent review or simultaneous external review, call the customer service number listed on the back of your identification card.

For more information

At your request and without charge, we will send you details from your health care plan if our decision was based on your benefits. If our decision was based on medical guidelines, we will provide you with the appropriate protocols and treatment criteria. If we involved a medical expert in making this decision, we will provide that person's credentials.

To request information about your plan or the medical guidelines used, or if you need help with the appeal process, call the MESSA member service number on the back of your identification card.

Other resources to help you

For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). You can also contact the Michigan Department of Insurance and Financial Services for assistance.

Other General Information

This section lists and explains certain general conditions that apply to your contract. These conditions may make a difference in how, where and when benefits are available to you.

Contest

A person seeking payment from MESSA/BCBSM, directly or indirectly, will be furnished with the specific reason(s) for denial of a claim and an explanation of any additional information required from, or on behalf of, the member or dependent for reconsideration of the claim in accordance with our claim review procedure.

No action or suit at law may be commenced upon or under this plan until 30 days after notice has been given by the member and/or covered dependent to us that the reconsidered decision is unacceptable, nor may such action be brought at all later than two years after such claim has arisen.

Coordination of Benefits

If you are a dependent under another medical plan you should consult your HSA administrator about the tax consequences for your HSA account.

This plan requires Coordination of Benefits (COB). COB is used when you are eligible for payment under more than one group health, dental, vision or automobile no-fault insurance plan. This provision is to assure you that your covered expenses will be paid, but that the combined payments of all programs will exceed neither the amount of the actual cost, nor the amount that would have been paid in the absence of other coverage. Under COB, the plan that has the first obligation to pay is called the primary plan.

The guidelines used to determine the primary plan are:

- ▶ A group plan or automobile no-fault insurance plan with no provision for the coordination of benefits is always primary, otherwise,
- ▶ The plan sponsored by the employer of the person receiving the treatment is primary
- ▶ If the claim is for a dependent child covered under two or more plans, the primary plan is that of the parent whose birthday anniversary falls earlier in the year. If the birthdates are identical, the plan that has covered the dependent the longest is primary. However, benefits for a child of divorced or separated spouses are determined in the following order:
 - Plan of parent having financial responsibility as designated by court decree
 - Custodial parent's plan
 - Plan of the custodial parent's new spouse (if remarried)
 - Plan of noncustodial parent
- ▶ If the primary plan cannot be determined using the above guidelines, then the plan covering the person the longest is primary. The only exception to this rule is that if the coverage is through a member who is retired or laid off, and there is also coverage through a plan not involving a retired or laid off employee, the plan covering the person who is not a retired or laid off employee will be primary.

These COB provisions shall apply to any government or tax-supported program, unless other procedures are required by law. These provisions shall also apply to any benefits or services provided by group student health programs. Except for automobile no-fault insurance coverage, these COB provisions shall not apply to any non-group policy.

Determination of medical necessity

There may be instances when benefit restrictions may be waived for in-network services. When medically appropriate, personal care physicians and/or network managers may obtain authorization for covered services beyond our normal payment rules.

Subrogation

In certain cases, we may have paid for health care services for you or your covered dependents that should have been paid by another person, insurance company or organization. In these cases:

- ▶ You grant us a lien or right of reimbursement on any money or other valuable consideration you or your covered dependents or representatives receive through a judgment, settlement, or otherwise. You grant us the lien or right of reimbursement regardless of:
 - 1) Whether the money or other valuable consideration is designated as economic or noneconomic damages,
 - 2) Whether the recovery is partial or complete, and
 - 3) Who holds the money or other valuable consideration or where it is held.
- ▶ You agree to inform us when you hire an attorney to represent you, and to inform your attorney of our rights under this certificate.
- ▶ You must do whatever is necessary to help us recover the money we paid to treat the injury that caused you to claim damages for personal injury.
- ▶ You must not settle a personal injury claim without first obtaining our written consent if we paid for the treatment you received for that injury.
- ▶ You agree to cooperate with us in our efforts to recover money we paid on behalf of you or your dependents.
- ▶ You acknowledge and agree that this certificate supersedes any made whole doctrine, collateral source rule common fund doctrine or other equitable distribution principles.

Release of information

Each person covered under this plan hereby authorizes physicians, hospitals and other providers of service to furnish to us, upon our request, information relating to services which the covered person is or may be entitled to under this plan. Physicians, hospitals and other providers of services are authorized to permit us to examine their records and to submit reports in the detail we request.

All information related to treatment of the covered person will remain confidential except for the purpose of determining rights and liabilities arising under this plan or when release is required by law.

Services before coverage begins or after coverage ends

Unless otherwise stated in this certificate, we will not pay for any services, treatment, care or supplies provided before your coverage under this certificate becomes effective or after your coverage ends. If your coverage begins or ends while you are an inpatient at a facility, our payment will be based on the facility's contract with BCBSM. Our payment may cover:

- ▶ The services, treatment, care or supplies you receive during the entire admission, or
- ▶ The services, treatment, care or supplies you receive while your coverage is in effect.

In addition, if you have other coverage when you are admitted to or discharged from a facility, your other carrier may be responsible for paying for the care you receive before the effective date of your MESSA coverage or after it ends.

Member liability

Certain technical enhancements, which may improve the safety or comfort of a procedure, may involve additional costs above and beyond the approved maximum payment level for the basic procedure. The costs of these enhancements are not covered. The provider must inform you of these costs. You then have the option of choosing any enhancements and assuming the liability for these additional charges.

Time limit for legal action

Legal action against us may not begin later than two years after we have received a complete claim for services. No action or lawsuit may be started until 30 days after you notify us that our decision under the claim review procedure is unacceptable.

What laws apply

This contract is subject to and interpreted under the laws of the state of Michigan.

Glossary of Health Care Terms

Accidental injury

Any physical damage caused by an action, object or substance outside the body, such as:

- ▶ Strains, sprains, cuts and bruises
- ▶ Allergic reactions caused by an outside force such as bee stings or other insect bites
- ▶ Extreme frostbite, sunburn, sunstroke
- ▶ Swallowing poisons
- ▶ Drug overdosing
- ▶ Inhaling smoke, carbon monoxide or fumes

Accredited hospital

A facility that has been endorsed by one of the following organizations: Joint Commission on the Accreditation of Healthcare Organizations, the American Osteopathic Association or the Commission on Accreditation of Rehabilitation Facilities (see the definition of [“Hospital”](#)).

Acute care

Medical care that requires a wide range of medical, surgical, obstetrical or pediatric treatment. It generally requires a hospital stay of less than 30 days.

Acute care facility

A facility that offers a wide range of medical, surgical, obstetric and pediatric services. These facilities primarily treat patients with conditions which require a hospital stay of less than 30 days. The facility is not used primarily for:

- ▶ Custodial, convalescent, tuberculosis or rest care
- ▶ Care of the aged or substance abusers
- ▶ Skilled nursing or other nursing care

Administrative costs (approved oncology trials)

Costs incurred by the organization sponsoring the approved oncology clinical trial. They may include, but are not limited to, the costs of gathering data, conducting statistical studies, meeting regulatory or contractual requirements, attending meetings or travel.

Affiliate Cancer Center

A health care provider that has contracted with an NCI-approved cancer center to provide treatment.

Allogeneic (Allogenic) bone marrow transplant

A procedure using another person’s bone marrow or peripheral blood stem cells to transplant into the patient. This includes syngeneic transplants (when the donor is the identical twin of the patient).

Ambulatory surgery

Elective surgery that does not require use of extensive hospital facilities and support systems, but is not usually performed in a doctor’s office.

Ambulatory surgery facility

A freestanding outpatient surgical facility offering surgery and related care that can be safely performed without the need for overnight inpatient hospital care. It does not include an office of a physician or other private practice office.

Ancillary services

Services other than room, board and nursing such as drugs, dressings, laboratory services and physical therapy.

Approved amount

The lower of the billed charge or our maximum payment level for the covered service. Deductibles, and/or coinsurance, which may be required of you, are subtracted from the approved amount before we make our payment.

Approved Clinical Trial

A Phase I, II, III or IV clinical trial that is conducted for the prevention, detection or treatment of cancer or other life-threatening disease or condition, and includes any of the following:

- ▶ a federally funded trial, as described in the Patient Protection and Affordable Care Act (PPACA)
- ▶ a trial conducted under an investigational new drug application reviewed by the FDA
- ▶ a drug trial that is exempt from having an investigational new drug application
- ▶ a study or investigation conducted by a federal department that meets the requirements of Section 2709 of the PPACA

Arthrocentesis

Surgical puncture of a joint to inject and/or withdraw fluid. When performed for temporomandibular joint (jaw joint) dysfunction, this surgery may be performed for reversible, irreversible or diagnostic purposes.

Approved hospice

A hospice provider that meets all state licensing and our approval requirements.

Attending physician

The physician in charge of a case and the one exercising overall responsibility for the patient's care:

- ▶ Within a facility (such as a hospital or other inpatient facility)
- ▶ As part of a treatment program
- ▶ In a clinic or private office setting

The attending physician may be responsible for coordination of care delivered by other physicians and/or ancillary staff.

Audiologist

A professional who is licensed or legally qualified in the state in which services are provided to perform audiometric and other procedures to assist in the diagnosis, treatment and management of individuals with hearing loss or balance problems.

Autism

- Autism Diagnostic Observation Schedule

The protocol available through western psychological services for diagnosing and assessing autism spectrum disorders or any other standardized diagnostic measure for autism spectrum disorders that is approved by the commissioner of the Office of Financial and Insurance Regulation, if the commissioner determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

- Autism Evaluation Center

An academic and/or hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the Autism Spectrum Disorders. The autism evaluation center must be approved by BCBSM to:

- ▶ Evaluate and **diagnose** the member as having one of the covered autism spectrum disorders and
- ▶ Recommend an initial high-level treatment plan for members with autism spectrum disorders

- Autism Spectrum Disorders

This includes Autism Disorder, Autism Pervasive Developmental Disorder Not Otherwise Specified, or Asperger's Disorder, as defined in the most current American Psychiatric Association Diagnostic and Statistical Manual.

- Behavioral Health Treatment

Evidence-based counseling and treatment programs, including applied behavior analysis, that meet both the following requirements:

- ▶ Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
- ▶ Are provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

- Line Therapy

Tutoring or other activities performed one-on-one with a person diagnosed with an Autism Spectrum Disorder. Line therapy must be performed in accordance with a treatment plan that has been designed by a BCBSM-approved autism evaluation center and a board-certified behavior analyst.

- Board Certified Behavior Analyst

An analyst certified by the Behavior Analyst Certification Board (BACB) at the time services are rendered.

NOTE: Board certified behavior analysts will be paid only for applied behavior analysis services. Any other treatment performed by board certified behavior analysts including, but not limited to, treatment of traumatic brain injuries will not be paid.

- Autism Evaluation

An evaluation must include a review of the member's clinical history and examination of the member. Based on the member's needs, as determined by the BCBSM-approved treatment center, an evaluation may also include cognitive assessment, audiologic evaluation, a communication assessment, assessment by an occupational or physical therapist and lead screening.

- Autism Prior Authorization Process

A process occurring before treatment is rendered in which a BCBSM nurse or case manager (or a BCBSM delegate/representative) approves all applied behavioral analysis services. A request for continued services will be authorized contingent on the member meeting mutually agreed upon (between BCBSM and the board certified behavior analyst) demonstration of measurable improvement and therapeutic progress, which can typically occur at 3, 6, or 9 month intervals or at other mutually agreed upon intervals after the onset of treatment.

- Autism Treatment Plan

A written, comprehensive, and individualized intervention plan that incorporates specific treatment goals and objectives and that is developed by a board certified or licensed provider who has the appropriate credentials and who is operating within his or her scope of practice, when the treatment of an autism spectrum disorder is first prescribed or ordered by a licensed physician or licensed psychologist.

Measurable improvement in the member's condition must be expected from the recommended treatment plan. Once treatment begins, the plan will be subject to periodic assessment by a BCBSM nurse or case manager at 3, 6 and/or 9 months or at mutually agreed upon intervals.

There are two levels to the treatment plan:

- ▶ The approved autism evaluation center will recommend an initial high-level treatment plan.
- ▶ The board certified behavior analyst will develop a detailed treatment plan specific to applied behavioral analysis treatment.

Autologous transplant

A procedure using the patient's own bone marrow or peripheral blood stem cells to transplant back into the patient.

BCBSM

Blue Cross Blue Shield of Michigan.

Benefit period

A specified period of time in which services are covered. Examples include hearing aids and related services, home health care and human organ.

Blue Cross Plan

Any nonprofit **hospital service plan** approved by the Blue Cross and Blue Shield Association at the time the hospital service is furnished.

Blue Shield Plan

Any nonprofit **medical service plan** approved by the Blue Cross and Blue Shield Association at the time the medical service is furnished.

BlueCard® participating PPO provider

A provider who participates with the Host Plan's PPO.

BlueCard PPO program

A program that allows MESSA/Blue Cross Blue Shield PPO members to receive health care services in other states and have claims processed by the Host Plan, subject to MESSA/Blue Cross and Blue Shield Association policies.

Calendar year

A period of time beginning January 1 and ending December 31 of the same year.

Carrier

An insurance company providing benefits for its members.

Certificate

An official document which describes a benefit, and any riders that amend this certificate.

Certified nurse midwife

A nurse who provides some maternity services and who:

- ▶ Is licensed as a registered nurse by the state of Michigan
- ▶ Has a specialty certification as a nurse midwife by the Michigan Board of Nursing
- ▶ Has current national certification as a midwife by an organization recognized by the Michigan Board of Nursing
- ▶ Participates with BCBSM

Certified nurse practitioner

A nurse who provides some medical services and who:

- ▶ Is licensed as a registered nurse by the state of Michigan
- ▶ Has a specialty certification as a certified nurse practitioner by the Michigan Board of Nursing
- ▶ Meets our qualification standards

Certified registered nurse anesthetist

A nurse who provides anesthesiology services and who:

- ▶ Is licensed as a registered nurse by the state of Michigan
- ▶ Has a specialty certification as a certified registered nurse anesthetist by the Michigan Board of Nursing
- ▶ Meets our qualification standards
- ▶ When outside the state of Michigan, is legally qualified to perform anesthesiology services in the state where the services are performed.

Chronic condition

A disease or ailment that lasts a long time or recurs frequently. Heart disease and arthritis are examples of chronic diseases.

Claim for damages

A lawsuit against, or demand to, another person or organization for compensation for an injury to a person.

Clinical trial

A study conducted on a group of patients to determine the effect of a treatment. For purposes of this plan, clinical trials include:

- ▶ Phase II – a study conducted on a number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment.

- Phase III – a study conducted on a much larger group of patients to compare the results of a new treatment of a condition to the results of conventional treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

Coinsurance

A percentage amount that you must pay for a covered service after your deductible has been met.

Contraception

Birth control drugs, devices (such as, but not limited to, diaphragms, IUDs and contraceptive implants) and injections designed to prevent pregnancy.

Contract

The insurance certificate and related riders, your signed application for coverage and your MESSA/BCBSM medical insurance ID card.

Conventional treatment

Treatment that has been scientifically proven to be safe and effective for treatment of the patient's condition.

Copayment

The flat dollar amount that you must pay for a covered service.

Covered services

The services, treatments or supplies identified as payable in your certificate. Such services must be medically necessary, as defined in this booklet, and ordered or performed by a provider that is legally authorized or licensed to order or perform the service. The provider must also be appropriately credentialed or privileged, or eligible, as determined by us, to order or perform the service and must comply with our policies when rendering the service.

Custodial care

Care primarily used in helping the patient with activities of daily living or meeting personal needs. Such care includes help in walking, getting in and out of bed, bathing, dressing and taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training.

Deductible

The amount that you must pay for covered services before benefits are paid by us.

Dental care

Care given to diagnose, treat, restore, fill, remove or replace teeth, or the structures supporting the teeth, including changing the bite or position of the teeth.

Designated Cancer Center

A site approved by the National Cancer Institute as a cancer center, comprehensive cancer center, clinical cancer center or an affiliate of one of these centers. The names of the approved centers and their affiliates are available to you and your physician upon request.

Detoxification

The medical process of removing an intoxicating or addictive substance from the body of a person who is dependent on that substance.

Developmental condition

A condition that can delay or completely stop the normal progression of speech development. Speech therapy may not help these conditions.

Dialysis

Removal of toxic substance(s) from the blood.

Direct supervision

The type of supervision that requires the supervising personnel to be in the same physical structure where the service is being performed.

Durable medical equipment

Equipment that can withstand repeated use and that is used for a medical purpose by a patient who is ill or injured. It may be used in the home.

Effective date

The date your coverage begins under this contract. This date is established by us.

Emergency medical condition

A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) which could cause a prudent layperson with average knowledge of health and medicine to reasonably expect that the absence of immediate medical attention would result in:

- ▶ The health of the patient (or with respect to a pregnant woman, the health of the woman and her unborn child) to be in serious jeopardy, or
- ▶ Serious impairment to bodily functions, or
- ▶ Serious dysfunction of any bodily organ or part (or with respect to a pregnant woman who is having contractions, there is inadequate time for a safe transfer to another hospital before delivery or the transfer may pose a threat to the health and safety of the woman or unborn child)

Emergency Services

Emergency Services include medical screening exams (as required under Section 1167 of the Social Security Act) that are within the capability of an emergency room department of a hospital, and include ancillary services routinely available in a hospital's emergency room to evaluate an emergency medical condition. They also include, within the capabilities of the staff and facilities available at the hospital, additional medical exams and treatment (as required under Section 1867 of the Social Security Act) to stabilize a patient.

End stage renal disease

Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

Exclusions

Situations, conditions, or services that are not covered by the subscriber's contract.

Experimental or investigational treatment

Treatment that has not been scientifically proven to be as safe and effective for treatment of the patient's condition as conventional treatment. Sometimes it is referred to as "experimental services."

Facility

A hospital or clinic that offers acute care or specialized treatment, such as substance abuse, rehabilitation treatment, skilled nursing care or physical therapy.

Fecal occult blood screening

A laboratory test to detect blood in feces or stool.

First aid

Treatment given for an accidental injury.

First degree relative

An immediate family member who is directly related to the patient; either a parent, sibling or child.

First priority security interest

The right to be paid before any other person from any money or other valuable consideration recovered by:

- ▶ Judgment or settlement of a legal action
- ▶ Settlement not due to legal action
- ▶ Undisputed payment

This right may be invoked without regard for:

- ▶ Whether plaintiff's recovery is partial or complete
- ▶ Who holds the recovery
- ▶ Where the recovery is held

Flexible sigmoidoscopy

A visual examination of the lower portion of the colon through the rectum, using a flexible instrument called a sigmoidoscope.

Food and Drug Administration (FDA)

An agency with the U.S. Department of Health and Human Services that is responsible for protecting the public health by assuring the safety, efficacy and security of human drugs.

Freestanding outpatient physical therapy facility

An independently owned and operated facility, separate from a hospital, that provides outpatient physical therapy services and functional occupational therapy or speech and language pathology services.

Genetic markers

Specific chemical groupings that are part of many body cells, including white blood cells. Called human leukocyte antigens (HLA), these six chemical groupings are inherited from each parent and are used to detect the constitutional similarity of one person to another. A complete HLA match occurs when all six of the clinically important markers of the donor are identical to those of the patient.

Gynecological examination

A history and physical examination of the female genital tract.

Hazardous medical condition

The dangerous state of health of a patient who is at risk for loss, harm, injury or death.

Health maintenance examination

A comprehensive history and physical examination including blood pressure measurement, ocular tonometry (measurement of pressure in the eye), skin examination for malignancy, breast examination, testicular examination, rectal examination and health counseling regarding potential risk factors.

Hemodialysis

The use of a machine to clean wastes from blood after the kidneys have failed.

High-dose chemotherapy

A procedure in which patients are given cell-destroying drugs in doses higher than those used in conventional therapy. Stem cell replacement is required after high-dose chemotherapy is given.

High-risk patient

An individual who has an increased risk of mortality or morbidity according to standard criteria recognized by the oncology community.

HLA genetic markers

Specific chemical groupings that are part of many body cells, including white blood cells. Called human leukocyte antigens, these chemical groupings are inherited from each parent and are used to detect the constitutional similarity of one person to another. Close (or the degree of) identity is determined by tests using serologic (test tube) methods and/or molecular (DNA fingerprinting) techniques. An HLA identical match occurs when the six clinically important markers of the donor are identical to those of the patient.

Home Health Care Agency

An organization that is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home.

Hospice

A public agency, private organization or subdivision of either, which primarily provides care for terminally ill persons.

Hospital

A facility that provides inpatient diagnostic, therapeutic and surgical services for injured or acutely ill persons on a 24-hour per day basis and is fully licensed and certified as a hospital as required by all applicable laws, and complies with all applicable national certification and accreditation standards.

Host plan

A Blue Cross and/or Blue Shield Plan outside of Michigan that participates in the BlueCard PPO Program and processes claims for services that you receive in that state.

Independent physical therapist

A physical therapist that provides some physical therapy services and who:

- ▶ Is licensed as a physical therapist by the state of Michigan

- ▶ Meets our qualification standards
- ▶ When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

In-network providers

Physicians or other health care professionals who have contracted to provide services to members enrolled in MESSA ABC and to accept the approved amount as payment in full. Deductibles and coinsurance, which may be required of you, are subtracted from the approved amount before we make our payment.

Lien

A first priority security interest in any money or other valuable consideration recovered by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees we paid as a result of the plaintiff's injuries.

Life threatening condition

A disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Line therapy

Tutoring or other activities performed one-on-one with a person diagnosed with an Autism Spectrum Disorder. Line therapy must be performed in accordance with a treatment plan that has been designed by a BCBSM-approved autism evaluation center and a board-certified behavior analyst.

Lobar lung

Transplantation of a portion of a lung from a brain dead or living donor to a recipient.

Mammogram

A low dose X-ray of the breast, two views per breast. The radiation machine must be state-authorized and specifically designed and used to perform mammography.

Maternity care

Hospital and professional services for any condition due to pregnancy except ectopic (tubal) pregnancy.

Maxillofacial prosthesis

A custom-made replacement of a missing part of the face or mouth such as an artificial eye, ear, nose or an obturator to close a cleft. Excludes replacement of teeth or appliances to support teeth.

Medical emergency

A condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by an accidental injury.

Medically necessary

A service must be **medically necessary** to be covered. There are three definitions: one applies to professional providers (M.D.s, D.O.s, podiatrists, chiropractors, fully licensed psychologists and oral surgeons); another applies to hospitals and Long Term Acute Care Hospitals (LTACHs); and a third applies to other providers.

Medical necessity for payment of professional provider services:

Health care services that a professional provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- ▶ In accordance with generally accepted standards of medical practice;
- ▶ Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's illness, injury or disease and
- ▶ Not primarily for the convenience of the member, professional provider, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's illness, injury or disease.

NOTE: "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician or provider society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Determination by us that allows for the payment of covered hospital services when all of the following conditions are met:

Medical necessity for payment of hospital and LTACH services:

- ▶ The covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease.
- ▶ The service, treatment, or supply is appropriate for the symptoms and is consistent with the diagnosis. (Appropriate means that the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.)
- ▶ For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.
- ▶ The service is not mainly for the convenience of the member or health care provider.
- ▶ The treatment is not generally regarded as experimental by us.
- ▶ The treatment is not determined to be medically inappropriate by the Utilization Quality and Health Management Programs or by any other MESSA/BCBSM programs (applies only to hospitals, not to LTACHs).

Medical necessity for payment of services of other providers:

- ▶ Determination by physicians acting for us, based on criteria and guidelines developed by physicians for us who are acting for their respective provider type or medical specialty, that:

The covered service is accepted as necessary and appropriate for the patient's condition. It is not mainly for the convenience of the member or physician.

In the case of diagnostic testing, the results are essential to and are used in the diagnosis or management of the patient's condition.

NOTE: In the absence of established criteria, medical necessity will be determined by physicians according to accepted standards and practices.

Member

An individual who is a member of MESSA. For purposes of benefits under this plan, "member" includes you and your covered dependents.

MESSA

Michigan Education Special Services Association.

Non-participating hospital

A hospital that has not signed a participation agreement with BCBSM or another Blue Cross plan to accept the approved amount as payment in full.

Non-participating provider

Physicians or other health care professionals who have not signed a participation agreement with BCBSM to accept the approved amount as payment in full. Non-participating providers, however, may agree to accept the approved amount on a per claim basis.

Occupational therapy

A rehabilitative service that uses specific activities and methods. The therapist is responsible for involving the patient in specific therapeutic tasks and activities to:

- ▶ Develop, improve or restore the performance of necessary neuro-musculoskeletal functions affected by an illness or injury or following surgery
- ▶ Help the patient learn to apply the newly restored or improved function to meet the demands of daily living
- ▶ Design and use splints, orthoses (such as universal cuffs and braces) and adaptive devices (such as door openers, bath stools, large handle eating utensils, lap trays and raised toilet seats)

Off-label

The use of a drug or device for clinical indications other than those stated in the labeling approved by the federal Food and Drug Administration.

Orthopedic shoes

Orthopedic shoes are prescribed by a physician or certified nurse practitioner to support or correct the bones, joints, muscles, tendons and ligaments of a weak or deformed foot.

Orthotic device

An appliance worn outside the body to correct a body defect of form or function.

Out-of-area services

Services available to members living or traveling outside a health plan's service area.

Out-of-network provider

Hospitals, physicians and other licensed facilities or health care professionals who have not contracted to provide services to members enrolled in MESSA ABC.

Outpatient psychiatric mental health facility

A licensed facility providing outpatient mental health services. It includes centers for mental health care such as hospitals, clinics, day treatment centers and community mental health centers as defined in the Federal Community Mental Health Centers Act of 1963, as amended.

Outpatient substance abuse treatment program

A program that provides medical and other services specifically for drug and alcohol abuse on an outpatient basis.

Pap smear

A method used to detect abnormal conditions, including cancer, of the female genital tract.

Partial liver

A portion of the liver taken from a brain dead or living donor.

Participating ambulatory surgery facility

A freestanding ambulatory surgery facility that has a signed participation agreement with BCBSM to accept the approved amount for covered services as full payment.

Participating hospital

A hospital that has signed a participation agreement with BCBSM to accept the approved amount as payment in full.

Participating providers

Physicians or other health care professionals who have signed a participation agreement with BCBSM to accept the approved amount as payment in full. Deductibles or coinsurance, which may be required of you, are subtracted from the approved amount before we make our payment.

Patient

The subscriber, or eligible dependent, who is awaiting or receiving medical care and treatment.

Per claim participation

Available to non-participating providers when they elect to accept the approved amount for specific covered services as payment in full.

Peripheral blood stem cell transplant

A procedure where blood stem cells are obtained by pheresis and infused into the patient's circulation.

Pheresis

Removal of blood from the donor or patient in order to separate and retain specific components of the blood (red cells, white cells, platelets, stem cells).

Physical therapy

The use of specific activities or methods to treat a disability when there is a loss of neuromusculoskeletal functions due to an illness or injury, or following surgery. Treatments include exercise and therapy of the patient's specific muscles or joints to restore or improve:

- ▶ Muscle strength
- ▶ Coordination
- ▶ Joint motion
- ▶ General mobility

Physician

A physician is a doctor of medicine (M.D.) or osteopathy (D.O.) legally qualified and licensed to practice medicine and perform surgery at the time and place services are performed. An optometrist, oral surgeon, dentist, podiatrist, doctor of chiropractic or other provider identified by us who is legally qualified and licensed to practice at the time and place services are performed is deemed to be a physician to the extent that the doctor renders services which he/she is legally qualified to perform.

A physician is also a person who is licensed under Act 368 Public Acts of Michigan 1978 as a fully licensed psychologist at the time services are performed. In a state where there are no certification or licensure requirements, a psychologist is one who is recognized as such by the appropriate professional society at the time and place services are performed.

Physicians may also be referred to as “practitioners.”

Plaintiff

The person who brings the lawsuit or claim for damages. The plaintiff may be the injured party or a representative of the injured party.

Practitioner

A physician (a doctor of medicine, osteopathy, podiatry or chiropractic) or a professional provider (a doctor of medicine or osteopathy; podiatrist, chiropractor, fully licensed psychologist or oral surgeon) or other professional provider who participates with BCBSM or who is an in-network provider. Practitioner may also be referred to as “participating” or “panel” or “in-network” provider.

Preferred Provider Organization (PPO)

A limited group of health care providers who have agreed to provide services to MESSA members enrolled in this PPO program. These providers accept the approved amount as payment in full for covered services.

Primary payer

The health care coverage plan that pays first when you are provided benefits by more than one carrier.

Primary Plan

The health care plan obligated to pay for services before any other health care plan that covers the member or patient.

Professional provider

This refers to one of the following:

- ▶ Doctor of medicine
- ▶ Fully licensed psychologist
- ▶ Doctor of osteopathy
- ▶ Oral surgeon
- ▶ Podiatrist
- ▶ Chiropractor
- ▶ Board certified behavior analyst
- ▶ Other providers as identified by us

Professional providers may also be referred to as “practitioners.”

Prosthetic device

An artificial appliance that:

- ▶ Replaces all or part of a body part or
- ▶ Replaces all or part of the functions of a permanently disabled or poorly functioning body organ

Provider

A person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care.

Psychologist

A practitioner of clinical psychology, counseling or guidance, who is fully licensed and certified by the state of Michigan or by the state where you receive services. Where there are no certification or licensure requirements, the psychologist must be recognized by the appropriate professional society.

Purging

A process that attempts to remove abnormal cells from a blood or bone marrow sample so that a clean sample with only normal blood producing cells is obtained.

Qualified individual

An individual eligible for coverage who participates in an approved clinical trial according to the trial protocol for treatment of cancer or other life-threatening disease or condition and either:

- ▶ The referring provider participates in the trial and has concluded that the individual's participation in the trial would be appropriate because the individual meets the trial's protocol, or
- ▶ The individual provides medical and scientific information establishing that the individual's participation in the trial would be appropriate because he/she meets the trial's protocols.

Radiology services

These include X-ray exams, radium, radon, cobalt therapy, ultrasound testing, radioisotopes, computerized axial tomography scans and magnetic resonance imaging scans.

Referral

The process by which the member's physician directs a patient to a specialist for a specific service or treatment plan.

Refractory patient

An individual who does not achieve clinical disappearance of the disease after standard therapy.

Relapse

When a disease recurs after a period of time following therapy. This period of time is defined by evidence-based literature pertaining to the patient's condition.

Research management

Services, such as diagnostic tests, which are performed solely to support the sponsoring organization's research. They are not necessary for treating the patient's condition.

Residential substance abuse treatment program

A program that provides medical and other services specifically for substance abusers in a facility that operates 24 hours a day, seven days a week. Treatment in a program is sometimes called "intermediate care."

Respite care

Relief to family members or other persons caring for terminally ill persons at home.

Right of reimbursement

Our right to make a claim against you, your dependents or representatives if you or they have received funds from another party responsible for benefits paid by us.

Routine patient costs

All items and services related to an approved clinical trial if they are covered under this plan for members who are not participants in an approved clinical trial. They do not include:

- ▶ The investigational item, device or service itself
- ▶ Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient, or
- ▶ A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

Screening services

Procedures or tests ordered for a patient (or for almost all patients of a particular class or group) that are not directly related to the diagnosis or treatment of a specific disease or injury. For example, tests routinely performed as part of a routine physical are considered screening.

Semi-private room

A hospital room with two beds.

Service area

The geographic area in which BCBSM is authorized to use the Blue Cross and Blue Shield name and service marks.

NOTE: BCBSM may contract with providers in areas contiguous with the state of Michigan. These providers' claims will not be subject to BlueCard rules.

Services

Surgery, care, treatment, supplies, devices, drugs or equipment given by a health care provider to diagnose or treat disease, injury, condition or pregnancy.

Skilled care

A level of care that can be given only by a licensed nurse to ensure the medical safety of the patient and the desired medical result. Such care must be:

- ▶ Ordered by the attending physician
- ▶ Medically necessary
- ▶ Provided by a registered nurse or a licensed practical nurse
- ▶ Supervised by a registered nurse or physician

Skilled nursing facilities

Facilities that provide continuous skilled nursing and other health care services by or under the supervision of a physician and a registered nurse.

Specialty hospitals

Hospitals that treat specific diseases, such as mental illness.

Specialty pharmaceuticals

Biotech drugs including high-cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. We determine which specific drugs are payable. This may include vaccines and chemotherapy drugs used in the treatment of cancer, but exclude injectable insulin. Select specialty pharmaceuticals require pre-authorization from us.

Specialty pharmacy

A company that specializes in specialty pharmaceuticals and the associated clinical management support.

Speech and language pathology services

Rehabilitative services that use specific activities or methods to treat speech, language or voice impairment due to an illness, injury or following surgery.

Stem cells

Primitive blood cells originating in the marrow, but also found in small quantities in the blood. These cells develop into mature blood elements including red cells, white cells and platelets.

Subrogation

Our assumption of your right, or the right of your dependents or representatives, to make a legal claim against or to receive money or other valuable consideration from another person, insurance company or organization.

Substance abuse

Taking alcohol or other drugs in amounts that can:

- ▶ Harm a person's physical, mental, social and economic well-being
- ▶ Cause a person to lose self-control as reflected by alterations of thought, mood, cognition, or behavior
- ▶ Endanger the safety or welfare of others because of the substance's habitual influence on the person

Substance abuse is alcohol or drug abuse or dependence as classified in the most current edition of the "International Classification of Diseases."

NOTE: Tobacco addictions are included in this definition

T-cell depleted infusion

A procedure in which T-cells (immunocompetent lymphocytes) are eliminated from peripheral blood stem cells, bone marrow or umbilical cord blood.

Technical surgical assistance

Aid given in a hospital to the operating physician during surgery by another physician not in charge of the case.

NOTE: Professional active assistance requires direct physical contact with the patient.

Terminally ill

A state of illness causing a person's life expectancy to be 12 months or less according to a medically justified opinion.

Total body irradiation

A procedure that exposes most of the body to ionizing radiation to produce an anti-tumor effect that helps prevent rejection of a bone marrow, peripheral blood stem cell or umbilical cord blood transplant.

Urgent care

Walk-in care needed for an unexpected illness or injury that requires immediate treatment to prevent long-term harm. Urgent care centers are not the same as emergency rooms or doctors' offices.

Voluntary sterilization

Sterilization that is not medically necessary according to generally accepted standards of medical practice and is performed strictly at the request of the patient.

We, us, our

Used when referring to Blue Cross Blue Shield of Michigan or MESSA.

You and your

Used when referring to any person covered under the subscriber's contract.

Life and Accidental Death & Dismemberment (AD&D) Benefits

\$5,000 benefit.

LINA (Life Insurance Company of North America, a subsidiary of Connecticut General Life Insurance Company), hereby certifies that members of Michigan Education Special Services Association (called the Policyholder), who are insured under Group Policy No. 57200, are subject to the terms and conditions of this policy and are insured for the benefits described in the pages of this booklet.

LINA insures the life and accidental death and dismemberment benefits. LINA will determine all benefit payments according to the provisions described in the booklet and the group policy.

The insurance is effective only if the person concerned is eligible, becomes covered and remains covered, in accordance with the terms and conditions of the policy. Coverage applies to members only, as defined in the [Eligibility Guidelines](#) section of this book. Dependents are not eligible for either the life insurance or accidental death and dismemberment insurance benefits.

This certificate replaces any other certificate issued to you describing these benefits.

LINA PF75134 amended by PF33333

General provisions

The following will explain the life and AD&D benefits available to you under the MESSA ABC plan.

Beneficiary

The beneficiary for your life and AD&D insurance for loss of life will be the person you name as shown in the records kept on the group insurance policy. If there is no named beneficiary living at your death, a lump sum will be paid to the first surviving class that follows:

- ▶ Spouse;
- ▶ Children;
- ▶ Parents;
- ▶ Brothers and sisters.

If none survive, the benefit will be paid to your estate in a lump sum.

If the beneficiary is a minor with no legal guardian, the minor's share may be paid to the adult (or adults) who, in LINA's opinion, has assumed custody and support of the minor. Payment may be made at a rate of up to \$50 a month.

If you die after having applied to convert your group life insurance to an individual insurance policy, the beneficiary named in the individual policy (or in the application for it) will receive any benefits payable under the group insurance policy.

Assignment of life insurance

There is only one assignment of your life insurance that is valid. The assignment which:

- ▶ states that it is without consideration;
- ▶ is made to a named beneficiary;
- ▶ is in writing; and
- ▶ is accepted by LINA. The assignment may be made without the consent of the beneficiary.

Once an assignment is accepted and while it remains in force, the assignee can exercise any of the rights and privileges under the group policy granted to you (including but not limited to, the conversion privilege), and becomes entitled to receive all claim payments under the insurance assigned with respect to which no beneficiary is designated by the assignee, unless the group policy states differently.

Acceptance of an assignment by LINA shall be without further liability as to any action or any payment or other settlement made by LINA before such acceptance. No assignment by you of your accidental death and dismemberment (AD&D) insurance is valid.

Life insurance benefits

The following information will explain your life insurance benefits under the MESSA ABC plan.

How payment is made

If you die while covered under the MESSA ABC plan, LINA will pay your beneficiary \$5,000. You may choose to have the benefit paid in a lump sum or in installments. You may also change your beneficiary or the method of payment at any time. Contact MESSA Group Services for the appropriate forms.

After your death, your beneficiary may choose the method of payment (if you have not already done so) and name a person to receive the benefit amount which would be paid to the beneficiary's estate in the event your beneficiary died before payment was made.

While disabled

If you become totally disabled by injury or disease and you are not able to perform any work for which you are reasonably qualified by learning or experience, your group life insurance coverage will continue for one year from the date the total disability is approved by LINA. You will continue to be covered for a benefit of \$5,000.

To be eligible for this extended coverage, you must be under 65 years old when you become disabled, and you must remain totally disabled during the year-long period.

Note: If you remain disabled, your contributions will be waived and your coverage will continue.

To minimize the financial burden during your disability, your contribution towards life insurance will be waived.

Your contributions will be waived on the date that LINA receives satisfactory proof of your disability – but no earlier than six months after the onset of the disability. If you remain disabled after the first year of continued benefits, your coverage will continue without any contributions from you as long as you provide LINA with proof of the disability annually, within the three-month period prior to the anniversary of the date the total disability was approved.

If you do any work for pay or gain, you are no longer considered totally disabled.

If you converted to an individual life insurance policy while you were disabled, you must return the individual policy to LINA with your first proof of total disability. LINA will refund any contributions you made for the individual policy.

LINA maintains the right to have its medical representative examine you to verify the disability, but will not do so more than once a year after your extended coverage has continued for more than two years. There is no cost to you for medical exams requested by LINA.

If you die while disabled

If you die while you are still disabled, your beneficiary will receive the life insurance benefits as soon as proof of your continued disability is received by LINA.

If you die after you have converted your policy, any amount paid under the individual policy will be deducted

from the amount due under the group life insurance policy and any contributions to the individual policy will be refunded to your beneficiary when the policy is returned.

When your extended coverage ends

Your extended coverage will end if you:

- ▶ cease to be totally disabled;
- ▶ fail to give required proof of your disability;
- ▶ fail to submit to a medical exam.

When your extended coverage ends, you can convert to an individual policy under the same conditions that would apply if you left school employment. See “After employment ends” below.

After employment ends

You have 31 days to convert to an individual policy and pay your first contribution. You won't need to take a health exam, but you will be limited in your choice of policy. The individual policy amount must be no greater than \$5,000, and you cannot convert to a policy that provides term insurance, universal or variable life insurance, benefits for disabilities, or extra benefits for accidental death.

If you have merely changed job classification, and are eligible for coverage under another group policy, the amount of your converted individual policy will be reduced by the amount of that group policy.

The individual policy will take effect 31 days after coverage under the group policy ends. Should you die in that period without converting, LINA will pay your beneficiary the amount you could have converted.

As an option to converting, you may continue your group life insurance on a direct payment basis by paying the required contribution for the cost of this insurance. MESSA will mail you a continuation notice for electing this option upon termination of your employment.

Contact MESSA Group Services for additional information.

After your Employer Terminates Participation in the Group Policy, or Coverage for Your Job Classification Ends

Again, you have 31 days to convert to an individual policy. The same conditions apply as if your employment ended. In addition, you must have been insured by the group policy for at least five years in a row.

The maximum amount of life insurance you may convert is \$2,000, less any amount you became eligible for under any other group policy during the 31-day conversion period.

Should you die in the 31-day period after your participation ends, or after the group policy itself terminates, and you were insured by the group policy for the preceding five years, you are still covered. LINA will pay your beneficiary the group life insurance policy amount, less the amount of any other group policy under which you became insured during that 31-day period, up to a maximum of \$2,000.

Even if you should die within the 31-day conversion period without converting, LINA will still pay your beneficiary the amount you could have converted.

Accidental Death and Dismemberment (AD&D) benefits

The following information will explain your AD&D benefits under the MESSA ABC program.

What is covered

As a MESSA member you have \$5,000 of AD&D insurance. If, while you are covered, you receive a bodily injury and experience a loss, LINA will pay you according to the schedule listed under “How AD&D Benefits are paid.”

In order to receive an AD&D benefit, the loss must:

- ▶ Be caused exclusively by external and accidental means;
- ▶ Be the direct result of the injury, independent of all other causes;
- ▶ Occur within 180 days from the date of the injury.

All benefits other than loss of life will be paid to you.

If you die, the benefits will be paid to your beneficiary. See “General Provisions” in this section for details about your beneficiary.

You may change your beneficiary at any time. Contact MESSA Group Services for the appropriate forms.

How AD&D benefits are paid

For the Loss of:

- ▶ Life
- ▶ Both hands or both feet
- ▶ Sight in both eyes
- ▶ Any two or more:
 - one foot
 - one hand
 - sight in one eye

You Receive:

- 100% of AD&D benefit (\$5,000)

For the Loss of:

- ▶ One hand, or
- ▶ One foot, or
- ▶ Sight in one eye, or
- ▶ Speech, or Hearing

You Receive:

- 50% of AD&D benefit (\$2,500)

For the Loss of:

- ▶ Thumb & index finger of the same hand

You Receive:

- 25% of AD&D benefit (\$1,250)

The following defines what is considered a loss:

Definition

Loss of one hand or foot: Loss by cutting off at or above the wrist or ankle joint

Loss of sight, speech, or hearing: Total loss that cannot be recovered

Loss of thumb & index finger: Loss by cutting off at the proximal phalangeal joint

When you suffer more than one loss

If you have more than one loss due to one accident, you will receive payment only for the loss with the largest benefit payout. You will only be paid for the loss resulting from the accident in question, regardless of any previous loss.

Losses not covered

No benefits will be paid for losses resulting from, or caused directly or indirectly by:

- ▶ Bodily or mental infirmity
- ▶ Disease or illness of any kind

- ▶ Self-destruction or intentionally self-inflicted injury
- ▶ Taking part in an insurrection or riot, war or act of war, service in any military or naval organization, unless the injuries are sustained while off-duty
- ▶ Taking part in, or as a result of taking part in, a felony

When coverage ends

AD&D coverage ends when your school employment ends or when you reach 65 years of age, whichever happens last. If your school employment ends before you reach 65, you must pay the required contribution for the cost of this insurance to continue this coverage until you reach age 65.

How to File a Claim for Life or AD&D Benefits

Life claims

Contact MESSA Group Services for the forms necessary to file a life insurance claim.

AD&D claims

Contact MESSA Group Services for the forms necessary to file an AD&D claim. AD&D claims are subject to the following:

Filing Deadline – Written notice of the event upon which the claim is based must be given:

- ▶ Within 20 days after the loss covered by the policy occurs or begins, or as soon after that time as is reasonably possible.

Notice – Notice must be given by, or on behalf of, the claimant to:

- ▶ LINA;
- ▶ MESSA; or
- ▶ any other authorized representative of LINA

The notice must include sufficient information to identify you.

Claim forms – On receipt of a notice of a claim, LINA or MESSA will give the claimant forms for filing proof of loss. If such forms have not been furnished within 15 days after the giving of the notice, the claimant can fulfill the terms of the policy as to proof of loss by giving written proof of:

- ▶ The occurrence of the loss
- ▶ The nature of the loss
- ▶ The extent of the loss

The proof of loss must be given within the time stated in “Proof of Loss” below.

Proof of Loss – Written proof of the loss must be given to LINA within 90 days after:

- ▶ The date of the loss; or
- ▶ The end of the period for which LINA is liable.

Late proof will be accepted only if it is furnished as soon as is reasonably possible. In no event, except in the absence of your legal capacity, will proof be accepted later than one year from the time proof would otherwise have been required. Itemized bills may be required as proof of loss.

Time of Payment of Claims – Benefits are payable upon receipt of due proof of loss.

Payment of Claims – Benefits for loss of life will be paid in accordance with the beneficiary named by you, if any, and the terms of the policy in effect at the time payment is made.

Any part of the benefit for which there is no such beneficiary or terms in effect will be paid to your estate. Any other accrued benefits not paid at your death may, at the option of LINA, be paid either to such beneficiary or your estate. Accidental dismemberment benefits will be payable to you.

If any benefit of the policy is payable to your estate, to you or your beneficiary while a minor, or to you or your beneficiary while not competent to give a valid release, LINA may pay such benefit, up to \$1,000, to anyone related by blood or by marriage to you or the beneficiary, and deemed by LINA to be justly entitled. Any such payment made in good faith will discharge LINA to the extent of such payment.

Physical Examination and Autopsy – At its own expense, LINA has the right to have a doctor examine any person when it deems it reasonably necessary and there is a claim pending under the policy. LINA also has the right to make an autopsy in the case of death unless the law forbids it.

Legal Actions – No one may sue for payment of a claim less than 60 days after proof of loss is furnished in accord with the terms of the policy. No one may bring suit more than three years after the date proof of loss is required by the policy.

Time Limit on Certain Defenses – A claim will not be denied nor will the validity of coverage be contested because of any statement with respect to insurability made by you while eligible for coverage under the policy, if:

- ▶ The insurance has been in force for at least two years before any such contest; and
- ▶ The person with respect to whom any such statement was made was alive during those two years.

Change of Beneficiary – You may change your beneficiary at any time; you do not need the consent of the beneficiary to make such change. Contact MESSA Group Services with any life and/or AD&D claim questions you may have.

Appendix A

Bone Marrow Transplant Covered Conditions

Allogeneic transplants are covered to treat:

- ▶ Acute lymphocytic leukemia (high-risk, refractory or relapsed patients)
- ▶ Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients)
- ▶ Acute myelogenous leukemia (high-risk, refractory or relapsed patients)
- ▶ Aplastic anemia (acquired or congenital, e.g., Fanconi's anemia or Diamond-Black fan syndrome)
- ▶ Beta-thalassemia
- ▶ Chronic myeloid leukemia
- ▶ Hodgkin's disease (high-risk, refractory or relapsed patients)
- ▶ Myelodysplastic syndromes
- ▶ Neuroblastoma (stage III or IV)
- ▶ Non-Hodgkin's lymphoma (high-risk, refractory or relapsed patients)
- ▶ Osteopetrosis
- ▶ Severe combined immune deficiency disease
- ▶ Wiskott-Aldrich syndrome
- ▶ Sickle cell anemia (ss or sc)
- ▶ Myelofibrosis
- ▶ Multiple myeloma
- ▶ Primary amyloidosis (AL)
- ▶ Glanzmann thrombasthenia
- ▶ Paroxysmal nocturnal hemoglobinuria
- ▶ Kostmann's syndrome
- ▶ Leukocyte adhesion deficiencies
- ▶ X-linked lymphoproliferative syndrome
- ▶ Primary, secondary and unspecified thrombocytopenia (e.g., megakaryocytic thrombocytopenia)
- ▶ Mantle cell lymphoma
- ▶ Congenital leukocyte dysfunction syndromes
- ▶ Congenital pure red cell aplasia
- ▶ Chronic lymphocytic leukemia
- ▶ Mucopolysaccharidoses (e.g., Hunter's, Hurler's, Sanfilippo, Maroteaux-Lamy variants) in patients who are neurologically intact
- ▶ Mucopolysaccharidoses (e.g., Gaucher's disease, metachromatic leukodystrophy, globoid cell leukodystrophy, adrenoleukodystrophy) for patients who have failed conventional therapy (e.g., diet, enzyme replacement) and who are neurologically intact
- ▶ Renal cell CA
- ▶ Plasmacytomas
- ▶ Other conditions for which treatment is non-experimental

Autologous transplants are covered to treat:

- ▶ Acute lymphocytic leukemia (high-risk, refractory or relapsed patients)
- ▶ Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients)
- ▶ Germ cell tumors of ovary, testis, mediastinum, retroperitoneum

- ▶ Hodgkin's disease (high-risk, refractory or relapsed patients)
- ▶ Neuroblastoma (stage III or IV)
- ▶ Non-Hodgkin's lymphoma (high-risk, refractory or relapsed patients)
- ▶ Multiple myeloma
- ▶ Primitive neuroectodermal tumors
- ▶ Ewing's sarcoma
- ▶ Medulloblastoma
- ▶ Wilms' tumor
- ▶ Primary amyloidosis
- ▶ Rhabdomyosarcoma
- ▶ Mantle cell lymphoma
- ▶ Other conditions for which treatment is non-experimental

Appendix B

Bone Marrow Transplant Covered Services & Exclusions

Allogeneic transplants

- ▶ Blood tests on first degree relatives to evaluate them as donors (if the tests are not covered by their insurance)
- ▶ Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established and the transplant is preapproved
- ▶ Infusion of colony stimulating growth factors
- ▶ Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood, if the donor is:
 - A first degree relative and matches at least four of the six important HLA genetic markers with the patient, or
 - Not a first degree relative but matches five of the six important HLA genetic markers with the patient. (In case of sickle cell anemia (ss or sc) or beta thalassemia, the donor must be an HLA identical sibling.)

NOTE: Harvesting and storage will be covered if it is not covered by the donor's insurance, but only when the recipient of harvested material is a MESSA member.

- ▶ High-dose chemotherapy and/or total body irradiation
- ▶ Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord blood
- ▶ T-cell depleted infusion
- ▶ Donor lymphocyte infusion
- ▶ Hospitalization

Autologous transplants

- ▶ Infusion of colony stimulating growth factors
- ▶ Harvesting (including peripheral blood stem cell pheresis) and storage of bone marrow and/or peripheral blood stem cells
- ▶ Purging and/or positive stem cell selection of bone marrow or peripheral blood stem cells
- ▶ High-dose chemotherapy and/or total body irradiation
- ▶ Infusion of bone marrow and/or peripheral blood stem cells
- ▶ Hospitalization

NOTE: A tandem autologous transplant is covered only when it treats germ cell tumors of the testes or multiple myeloma.

We do not pay for:

- ▶ Services rendered to a transplant recipient who is not a MESSA member
- ▶ Services rendered to a donor when the donor's health care coverage will pay
- ▶ Services rendered to a donor when the transplant recipient is not a MESSA member
- ▶ Expenses related to travel or lodging for the donor or recipient
- ▶ An autologous tandem transplant for any condition other than germ cell tumors of the testes or multiple myeloma
- ▶ An allogeneic tandem transplant
- ▶ Search of an international donor registry
- ▶ The routine harvesting and storage costs of bone marrow, peripheral blood stem cells or a newborn's umbilical cord blood if not intended for transplant within one year
- ▶ Any other services or admissions related to any of the above named exclusions

Appendix C

MESSA ABC Rx Plan (Prescription Drug Booklet)

Your MESSA ABC Plan requires you to pay the actual cost for prescription drugs, along with medical services, until your applicable deductible has been met. This is a requirement for HSA-qualified plans. There is a provision in the regulations that allows for some preventive drugs to be covered right away, with no deductible and no coinsurance. For a current list of these covered prescriptions go to [MESSA ABC Free Preventive Drug List](#).

Section 1: Prescription Drug Benefits (for a list of definitions see Section 5 of Appendix C)

1.1 Deductible

Under federal law governing HSA-qualified plans, most prescription drugs are subject to the medical plan's deductible.

1.2 Copayments

Once your applicable deductible has been met, your copayment for each covered drug or refill when obtained from a network pharmacy is:

- ▶ \$2 for generic drugs in certain therapeutic classes used to treat specific chronic conditions. As of 7/1/12 the covered conditions are asthma and diabetes.
- ▶ \$10 for all other generic drugs
- ▶ \$10 for specific, Over-the-Counter (OTC) medications – for the treatment of seasonal allergies and heartburn – with a written prescription. As of 10/11 the covered OTC medications for the treatment of seasonal allergies are Allegra®, Allegra D®, Claritin®, Claritin D®, Zyrtec®, and Zyrtec D®. The covered OTC medications for the treatment of heartburn are Prevacid®, Prilosec®, and Zegerid®.
- ▶ \$20 for specific brand-name drugs for which there is no generic or therapeutic equivalent. As of 7/1/12 this includes insulin and glucagon emergency kits for diabetics, fast-acting or long-lasting inhalers and Zyflo® and Zyflo CR® for the treatment of asthma.
- ▶ \$40 for all other brand name drugs, including single-source drugs where no generic is available.

Note: If the approved amount is less than the copayment, you pay only the approved amount for the drug. We reserve the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill.

1.3 Maximum out-of-pocket Expense

Your combined annual out-of-pocket maximum for both medical insurance and purchases from a retail or mail-order network pharmacy is:

In-network:

- ▶ Deductible plus \$1,000 for single
- ▶ Deductible plus \$2,000 for 2-person and family

Out-of-network:

- ▶ Deductible plus \$2,000 for single
- ▶ Deductible plus \$4,000 for 2-person and family

Once you have met an annual out-of-pocket maximum, no more copayments will be required for the remainder of the calendar year.

The following do not apply toward your annual out-of-pocket copayment maximum:

- ▶ covered drugs obtained from a non-network pharmacy (both retail and mail-order);
- ▶ amounts that exceed our approved amount for covered drugs or non-network retail sanction amounts;
- ▶ payment for non-covered drugs; and
- ▶ any reimbursement when the member pays up front.

1.4 Covered Drugs Obtained From an In-network Pharmacy

You have the advantage of paying no more than the approved amount which is discounted from the retail cost of the medication. This also applies to pharmacies in the BCBSM 90-day Retail Pharmacy program. You can get prescriptions for up to a 34-day supply or 84-90 days. There is no coverage for prescriptions written for a 35- to 83-day supply of medication from the 90-day retail network program.

1.5 Covered Drugs Obtained From an Out-of-network Pharmacy

When a pharmacy fills a prescription for a covered drug, you must pay the pharmacist the full cost of the drug and submit a claim form and proof of payment to MESSA.

Once your applicable deductible has been satisfied, MESSA will reimburse you 75 percent (100 percent for emergency

pharmacy services) of the approved amount for the drug, minus your copayment. See [How to File a Claim](#) in Section 2.

1.6 Express Scripts - Home Delivery Pharmacy Service

Ordering your medications through Express Scripts may be a convenient option for you. Once your deductible has been met, you pay one copayment for up to a 34-day supply of a covered drug or refill obtained from MESSA's exclusive mail-order provider.

Your copayment for a 35- to 90-day supply of a covered drug or refill obtained from our exclusive mail-order provider is double the amount listed above. This provides you with up to a 90-day supply for two copayments instead of three (after the deductible).

Reminder: If you choose a brand name drug when a generic is available, costs above the approved amount for the drug will be your responsibility and will not apply to the annual out-of-pocket limit. Payment must be made directly to the mail-order provider. Specialty medications may be handled separately. See Definitions in Section 5.

1.7 90-Day Retail Drug Coverage (mail order alternative)

We will cover prescription drug benefits for up to a 90-day supply of medications obtained from a 90-day retail network pharmacy as follows:

For up to a 34-day supply of medication from a 90-day retail network pharmacy, your copayment is:

- ▶ [\\$0 for specific preventive medications](#)
- ▶ \$2 for generic drugs in specific therapeutic classes prescribed for the treatment of specified chronic conditions
- ▶ \$10 for generic drugs
- ▶ \$10 for specific OTC drugs with prescription
- ▶ \$20 for specific brand name drugs for which there is no generic or therapeutic equivalent
- ▶ \$40 for all other brand name drugs, including single-source drugs where no generic is available (plus the cost difference between the BCBSM-approved amount and the actual retail cost of the drug when the member insists on a brand name when a generic is available and medically appropriate)

For a 35- to 83-day supply of medication there is no coverage available from the 90-day retail network program.

For an 84- to 90-day supply of medication from a 90-day retail network pharmacy, the copayment is double that for a single month.

Specialty medications may be handled separately. See [Definitions](#) in Section 5.

When a network retail or mail-order provider fills a prescription with a MAC drug, you will only be charged the discounted, approved amount of the generic drug. However, if you obtain a brand name drug when a generic equivalent drug is available, even if your physician writes "Dispense as Written" or "DAW" on the prescription, you will be charged the allowed amount for that medication. Even with our discounts, the cost difference may be substantial.

- ▶ Amounts you pay that are in excess of the approved amount for these brand name drugs that have generic equivalents will NOT count towards meeting your annual out-of-pocket limit.

Exception: If your prescribing physician requests and receives authorization for a brand name drug from BCBSM's Pharmacy Services Department and writes "Dispense as Written" or "DAW" on the prescription, you will not be charged the amount in excess of the approved amount. Only a physician may contact the Pharmacy Services Department to request an exception. Consideration of an exception is based on documentation that the patient has tried the generic and it is not appropriate due to side effects or lack of efficacy.

1.8 Covered Drugs/Quantities

We cover the following items:

- ▶ "Rx only" drugs (those requiring a prescription under federal law);
- ▶ compounded drugs containing bulk chemical powders that we have approved for payment;
- ▶ state-controlled drugs;
- ▶ injectable insulin;
- ▶ needles and syringes for covered injectable drugs, insulin or self-administered chemotherapeutic drugs; and
- ▶ "Rx only" oral, injectable or self-administered contraceptive medications

Once your applicable deductible has been met, prescriptions will be covered for up to a 34-day supply of a covered drug or refill for a single copayment until you reach the annual out-of-pocket maximum.

Section 2: How to File a Claim

The prescription drug benefits provided by this program are underwritten by BCBSM. This means you can take advantage of the program provider network and eliminate the need for any paperwork on your part. The following information explains how providers are paid.

Your prescription drug claims are paid based on the network status of the pharmacy involved.

Participating or Panel Pharmacy (hereinafter referred to as in-network) – To obtain your prescription drug or refill from a network pharmacy or provider:

- show your MESSA/BCBSM identification card to the pharmacist at the time of purchase; and
- pay the network pharmacist the discounted price for each prescription or refill until your deductible has been met. After that, the copayments described in Section 1.2 will apply until your annual out-of-pocket maximum has been satisfied.

Non-Participating or Non-Panel Pharmacy (hereinafter referred to as out-of-network) - If you obtain prescriptions from an out-of-network provider, you will not have access to the discounted pricing available from in-network providers. To obtain your prescription from a non-network pharmacy, you will need to pay the full cost of the medication. For reimbursement, have the pharmacist give you an itemized statement/receipt, indicating the following information:

- member's name and enrollee number;
- full name of patient for whom the prescription is being filled;
- name, address, and telephone number of the pharmacy;
- prescription number;
- National Drug Code (NDC) code;
- quantity of prescription and number of days supplied;
- description, name and strength of drug; and
- price of each prescription, including applicable sales tax.

Send your itemized receipt to MESSA for payment. Once your out-of-network deductible has been satisfied, you will be reimbursed 75 percent of the approved amount (100 percent for emergency pharmacy services), minus the applicable MESSA ABC Rx Plan copayment.

2:1 Filing Deadlines

All claims must be submitted to MESSA/BCBSM within two years of the date of service.

If you have any questions regarding your prescription drug claims, please call the MESSA Member Service Center.

Section 3: Exclusions and Limitations

We will not pay for the following:

- covered drugs obtained from other than the designated mail-order pharmacies, including Internet pharmacies;
- more than a 90-day mail order or 90-day retail network supply of a covered drug or refill;
- therapeutic devices or appliances including, but not limited to, hypodermic or disposable needles and syringes when not dispensed with insulin or self-administered chemotherapeutic drugs, support garments, or other non-medical items;
- drugs prescribed for cosmetic purposes;
- the charge for any prescription refill in excess of the number specified by the prescriber; or any refill dispensed one year after the prescriber's prescription;
- any vaccine given solely to resist infectious diseases;
- administration of covered drugs or insulin (such as injections);
- more than a 34-day retail supply of a covered drug or refill, unless it is an 84-90 day supply dispensed at a 90-day retail network pharmacy;
- any drug we determine to be experimental or investigational;
- any covered drug entirely consumed at the time and place of the prescription;
- anything other than covered drugs and services;
- any medication that does not require a prescription, except insulin;
- diagnostic agents;
- any drug or device prescribed for "indications" (uses) other than those specifically approved by the Federal Food and Drug Administration (FDA);

- drugs which are not labeled, “Rx only,” except for state-controlled drugs;
- covered drugs or services dispensed to a member when such services are benefits under other MESSA/BCBSM certificates;
- compounded drugs that contain any bulk chemical powders that are not approved by us;
- non-self-administered injectable drugs;
- more than the quantities and doses allowed by us per prescription of select drugs.
- drugs or services covered by government sponsored health care programs, such as Tricare (formerly CHAMPUS);
- drugs or services obtained before the effective date of this coverage, or after the coverage ends;
- refills distributed one year or more after the date of the prescription.

Section 4: Additional Plan Information

4.1 Experimental Services

Prescription drugs or services which we determine to be experimental or investigational are not covered. See Section 5: Definitions below.

4.2 Personal Costs

We will not pay for care, services, supplies, or devices which are personal or convenience items. BCBSM and MESSA are not responsible for any claims for injury or damage due to the manufacturing, compounding, dispensing, or use of any prescription drug or injectable insulin whether or not covered under this plan.

Section 5: Definitions

Terms used in this plan have the following meanings:

Approved Amount – The lower of the billed charge or the sum of the drug cost plus the dispensing fee (and incentive fee, if applicable) for a covered drug or service. The drug cost, dispensing fee and incentive fee are set according to our contracts with pharmacies. The approved amount is not reduced by rebates or other credits received directly or indirectly from the drug manufacturer. Copayments that may be required of you are subtracted from the approved amount before we make our payment.

Clinical Trial – A study conducted on a group of patients to determine the effect of a treatment. Clinical trials generally include the following phases:

- Phase I: a study conducted on a small number of patients to determine what the side effect(s) and appropriate dose of treatment may be for a certain disease or condition.
- Phase II: a study conducted on a larger number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effect of the treatment.
- Phase III: a study conducted on a much larger group of patients to compare the new treatment of a condition to a conventional or standard treatment. Phase III gives an indication as to whether the new treatment leads to better, worse, or no change in outcome.

Copayment – The portion of the approved amount that you must pay for a covered drug or service.

Note: A separate copayment is not required for covered disposable needles and syringes when dispensed within 120 days of an insulin or chemotherapeutic drug prescription refill.

Cosmetic Drugs – Prescription drugs which are used primarily for improving appearance rather than for treating a disease.

Covered Drug – Injectable insulin, a state-controlled drug, or any FDA-approved drug, if the following conditions are met:

- a prescription must be issued by a prescriber who is legally authorized to prescribe drugs for human use;
- the cost of the drug must not be included in the charge for other services or supplies provided to you;
- the drug is not consumed at the time and place where the prescription is written

The drug must also be approved by the FDA for treatment of the condition for which it is prescribed or recognized for treatment of the condition for which it is prescribed by one of the following sources:

- The American Hospital Formulary Service Drug Information
- The US Pharmacopoeia Dispensing Information, Volume 1, “Drug Information for the Health Care Professional”
- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal

Any compounded drugs are covered if they meet all the above requirements, subject to the provisions and exclusions of this prescription program.

Covered Services – Specific drug products or supplies used to treat medical conditions, such as disposable needles and syringes when dispensed with insulin, or chemotherapeutic drugs.

Diagnostic Agents – Substances used to diagnose, rather than treat, a condition or disease.

Dispensing Fee – The amount we pay to a provider for filling a prescription.

Emergency Pharmacy Services – Services needed immediately because an injury or an illness occurred suddenly and unexpectedly.

Experimental or Investigational – A service, procedure, treatment, device, drug or supply which has not been scientifically demonstrated to be safe and effective for treatment of the patient’s condition.

The service may be determined to be experimental or investigational when there is:

- a written experimental or investigational plan by the attending provider or another provider studying the same service; or
- a written informed consent used by the treating provider in which the service is referred to as experimental, investigational, or other than conventional or standard therapy; or
- an on-going clinical trial.

Federal Legend Drug – Any medicinal substance which bears the legend: “Caution: Federal Law prohibits dispensing without a prescription.”

Generic Equivalent – A prescription drug which contains the same active ingredients, is identical in strength and dosage form, and is administered in the same way as the brand name drug.

Maximum Allowable Cost (MAC) – The most BCBSM will pay for certain covered drugs we have identified under the MAC program. (Also known as the approved amount.)

Maximum Allowable Cost Program – A BCBSM cost containment program that encourages the use of generic drugs. The MAC Program places a cost limit on certain drugs for which a generically equivalent drug is available at a lower cost.

Network Pharmacy – A provider selected by BCBSM to provide covered drugs through the MESSA Preferred Rx program. Network pharmacies have agreed to accept the approved amount as payment in full for covered drugs or services provided to members.

Ninety (90)-Day Pharmacy – A pharmacy who has an agreement with BCBSM to provide covered drugs through the 90-Day Retail Drug Network. Network pharmacies have agreed to accept the approved amount as payment in full for the covered drugs provided to members.

Non-Network Mail-Order Provider – A provider who has not been selected to provide covered drugs through our PPO program. Non-network mail-order providers have not agreed to accept the approved amount as payment in full for covered drugs provided to members in our PPO mail-order program.

Non-Network Retail Pharmacy – A provider who has not been selected for participation and has not signed an agreement to provide covered drugs through MESSA’s Preferred Rx program. Non-network pharmacies have not agreed to accept the approved amount as payment in full for covered drugs or services provided to members.

Pharmacy – A licensed establishment where a licensed pharmacist dispenses prescription drugs under the laws of the state where the pharmacist practices.

Prescriber – A health care professional authorized by law to prescribe federal legend drugs for the treatment of human conditions.

Prescription – An order for medication written by a prescriber as defined in this section.

Provider – A pharmacy legally licensed to dispense prescription drugs.

Specialty Medications – Biotech drugs, including high-cost infused or injectable medications, oral and self-injectable drugs and other drugs related to specialty disease categories or other categories. The term “Specialty Medications” excludes injectable insulin.

State-Controlled Drugs – Drugs which are not federal legend drugs and are normally sold over-the-counter, but require a prescription under state law when large quantities are dispensed.