



MESSA ABC & 3-Tier RX



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

Plan 1

Coverage for: Individual/Family | Plan Type: PPO



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

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.messa.org](http://www.messa.org) or call MESSA at 1-800-336-0013. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call MESSA at 1-800-336-0013 to request a copy.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall <u>deductible</u> ?	\$1,700 Individual/ \$3,400 Family	\$3,400 Individual/ \$6,800 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .		This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at ( <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> ).
Are there other <u>deductibles</u> for specific services?	No.		You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? (May include a <u>coinsurance</u> maximum)	\$3,700 Individual/ \$7,400 Family	\$7,400 Individual/ \$14,800 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, <u>balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this <u>plan</u> doesn't cover.		Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. For a list of <u>network providers</u> see ( <a href="http://www.messa.org">http://www.messa.org</a> ) or call MESSA at 800-336-0013		This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.		You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	No Charge	20% <u>coinsurance</u>	Members 18 years and older have access to Virtual Primary Care visits by a BCBSM selected vendor.
	<u>Specialist</u> visit	No Charge	20% <u>coinsurance</u>	None
	<u>Preventive care/ screening/ immunization</u>	No Charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No Charge	20% <u>coinsurance</u>	May require <u>prior authorization</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.messa.org">www.messa.org</a>	Generic drugs	\$10 <u>copay</u> /prescription for retail 34-day supply; \$25 <u>copay</u> /prescription for retail or mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	<u>Prior authorization</u> , step therapy and quantity limits may apply to select drugs. <u>Preventive</u> drugs covered in full. Mail order drugs are not covered out-of-network
	Preferred brand-name drugs	20% <u>coinsurance</u> of the approved amount, but not less than \$40 <u>copay</u> /prescription or more than \$80 <u>copay</u> /prescription for retail 34-day supply; 20% <u>coinsurance</u> of the approved amount, but not less than \$100 <u>copay</u> /prescription or more than \$200 <u>copay</u> /prescription for retail or mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	
	Non-preferred brand-name drugs	20% <u>coinsurance</u> of the approved amount, but not less than \$60 <u>copay</u> /prescription or more than \$100 <u>copay</u> /prescription for retail 34-day supply; 20% <u>coinsurance</u> of the approved amount, but not less than \$150 <u>copay</u> /prescription or more than \$250 <u>copay</u> /prescription for retail or mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No Charge	20% <u>coinsurance</u>	None
	Physician/surgeon fees	No Charge	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	No Charge	No Charge	None
	<u>Emergency medical transportation</u>	No Charge	No Charge	Mileage limits apply
	<u>Urgent care</u>	No Charge	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% <u>coinsurance</u>	<u>Prior authorization</u> is required.
	Physician/surgeon fee	No Charge	20% <u>coinsurance</u>	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	No Charge	20% <u>coinsurance</u>	None
	Inpatient services	No Charge	20% <u>coinsurance</u>	<u>Prior authorization</u> is required.
If you are pregnant	Office visits	No Charge; <u>deductible</u> does not apply	20% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services <u>cost share</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	No Charge	20% <u>coinsurance</u>	None
	Childbirth/delivery facility services	No Charge	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No Charge	No Charge	Physician certification required.
	<u>Rehabilitation services</u>	No Charge	20% <u>coinsurance</u>	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	<u>Habilitation services</u>	No Charge for Applied Behavior Analysis; No Charge for Physical, Speech and Occupational Therapy	20% <u>coinsurance</u>	Prior authorization is required for applied behavior analysis (ABA). Services rendered by an approved licensed behavior analyst (LBA) will apply the In-network cost-sharing.
	<u>Skilled nursing care</u>	No Charge	No Charge	Physician certification required. Limited to 120 days per member per calendar year
	<u>Durable medical equipment</u>	No Charge	No Charge	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	<u>Hospice services</u>	No Charge	No Charge	Physician certification required. Unlimited visits.
<b>If your child needs dental or eye care</b> For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

## Excluded Services & Other Covered Services:

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

- Cosmetic Surgery
- Dental care (Adult)
- Long term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Acupuncture treatment
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See (<http://www.messa.org>)
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S
- Private-duty nursing

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov) or by calling 1-800-324-6172. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact MESSA by calling 1-800-336-0013.

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

### **Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### **Does this plan meet Minimum Value Standards? Yes**

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

### **Language Access Services: See Addendum**

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

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## About these Coverage Examples:



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

### Peg is Having a Baby

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

■ <b>The plan's overall deductible</b>	<b>\$1,700</b>
■ <b>Specialist coinsurance</b>	<b>0%</b>
■ <b>Hospital (facility) coinsurance</b>	<b>0%</b>
■ <b>Other coinsurance</b>	<b>0%</b>

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,770</b>

### Managing Joe's Type 2 Diabetes

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

■ <b>The plan's overall deductible</b>	<b>\$1,700</b>
■ <b>Specialist coinsurance</b>	<b>0%</b>
■ <b>Hospital (facility) coinsurance</b>	<b>0%</b>
■ <b>Other coinsurance</b>	<b>0%</b>

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$500
<u>What isn't covered</u>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,320</b>

### Mia's Simple Fracture

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

■ <b>The plan's overall deductible</b>	<b>\$1,700</b>
■ <b>Specialist coinsurance</b>	<b>0%</b>
■ <b>Hospital (facility) coinsurance</b>	<b>0%</b>
■ <b>Other coinsurance</b>	<b>0%</b>

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
Diagnostic tests (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,710</b>

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or coinsurance, or benefits not otherwise covered.

## Language services

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

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

إذا كنت أنت أو شخص آخر تساعد به حاجة إلى المساعدة، فمن حَقَّكَ الحصول على المساعدة والمعلومات بلغتك بدون أي كلفة للتحدث إلى مترجم، اتصل بالرقم المخصص الموجود على ظهر بطاقتك MESSA لخدمات أعضاء.

如果您，或是您正在協助的對象，需要協助，您有權利免費已您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的MESSA會員服務電話。

Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ, cần sự giúp đỡ, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, hãy gọi đến số dịch vụ thành viên MESSA trên mặt sau của thẻ.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e shërbimit të anëtarësimit MESSA në anën e pasme të kartës tuaj.

귀하 또는 귀하가 도움을 제공하는 누군가가 도움이 필요한 경우, 귀하는 귀하의 모국어로 무료로 도움과 정보를 제공 받을 권리를 갖고 있습니다. 통역사의 도움을 받으려면 카드 뒷면의 MESSA 회원 서비스 번호로 전화하십시오.

যদি আপনার বা আপনদ সাহায্য কররন এমন কাররা সহায়তার প্রয়োজন হয়, তাহলে ককারণা খরচ ছাড়াই আপনার ভাষায় সহায়তা ও তথ্য পাওয়ার অধিকার ররররর। ককারণা কাভাষীর সারথ কখা বেরত, আপনার কারডের কপছরন প্রিত MESSA সিস্য পদররররর নস্থরর কে কররন।

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

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

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

Если Вам или лицу, которому Вы помогаете, нужна помощь, то Вы имеете право на бесплатное получение помощи и информации на Вашем языке. Для разговора с переводчиком позвоните по номеру

телефона MESSA отдела обслуживания клиентов, указанному на обратной стороне Вашей карты. Ukoliko je vama ili nekom kome pomažete potrebna pomoć, imate pravo dobiti pomoć i informaciju na vašem jeziku besplatno. Da biste razgovarali sa prevodiocem, pozovite broj za usluge članova MESSA na zadnjoj strani vaše kartice.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang interpreter, tumawag sa numero para sa mga serbisyo sa miyembro ng MESSA na nasa likuran ng iyong card.

## Important disclosure

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

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



MESSA Choices & 3 Tier RX



MESSA PPO

Coverage for: Individual/Family | Plan Type: PPO

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	In-Network	Out-of-Network	
What is the overall <u>deductible</u> ?	\$500 Individual/ \$1,000 Family	\$1,000 Individual/ \$2,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .		This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at ( <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> ).
Are there other <u>deductibles</u> for specific services?	No.		You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? (May include a <u>coinsurance</u> maximum)	\$1,500 Individual/ \$3,000 Family	\$3,000 Individual/ \$6,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, <u>balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this <u>plan</u> doesn't cover.		Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. For a list of <u>network providers</u> see ( <a href="http://www.messa.org">http://www.messa.org</a> ) or call MESSA at 800-336-0013		This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.		You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /office visit	20% <u>coinsurance</u>	Members 18 years and older have access to Virtual Primary Care visits by a BCBSM selected vendor.
	<u>Specialist</u> visit	\$20 <u>copay</u> /office visit	20% <u>coinsurance</u>	None
	<u>Preventive care/ screening/ immunization</u>	No Charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No Charge	20% <u>coinsurance</u>	May require <u>prior authorization</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.messa.org">www.messa.org</a>	Generic drugs	\$10 <u>copay</u> /prescription for retail 34-day supply; \$25 <u>copay</u> /prescription for retail or mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	<u>Prior authorization</u> , step therapy and quantity limits may apply to select drugs. <u>Preventive</u> drugs covered in full. Your Prescription drug coverage has a separate out-of-pocket limit of \$2,000/\$4,000. Mail order drugs are not covered out-of-network
	Preferred brand-name drugs	20% <u>coinsurance</u> of the approved amount, but not less than \$40 <u>copay</u> /prescription or more than \$80 <u>copay</u> /prescription for retail 34-day supply; 20% <u>coinsurance</u> of the approved amount, but not less than \$100 <u>copay</u> /prescription or more than \$200 <u>copay</u> /prescription for retail or mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	
	Non-preferred brand-name drugs	20% <u>coinsurance</u> of the approved amount, but not less than \$60 <u>copay</u> /prescription or more than \$100 <u>copay</u> /prescription for retail 34-day supply; 20% <u>coinsurance</u> of the approved amount, but not less than \$150 <u>copay</u> /prescription or more than \$250 <u>copay</u> /prescription for retail or mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No Charge	20% <u>coinsurance</u>	None
	Physician/surgeon fees	No Charge	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$50 <u>copay</u> /visit	\$50 <u>copay</u> /visit	<u>Copay</u> waived if admitted or for an accidental injury.
	<u>Emergency medical transportation</u>	No Charge	No Charge	Mileage limits apply
	<u>Urgent care</u>	\$25 <u>copay</u> /visit	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% <u>coinsurance</u>	<u>Prior authorization</u> is required.
	Physician/surgeon fee	No Charge	20% <u>coinsurance</u>	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	No Charge	20% <u>coinsurance</u>	None
	Inpatient services	No Charge	20% <u>coinsurance</u>	<u>Prior authorization</u> is required.
If you are pregnant	Office visits	No Charge; <u>deductible</u> does not apply	20% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services <u>cost share</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	No Charge	20% <u>coinsurance</u>	None
	Childbirth/delivery facility services	No Charge	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No Charge	No Charge	Physician certification required.
	<u>Rehabilitation services</u>	No Charge	20% <u>coinsurance</u>	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	<u>Habilitation services</u>	\$20 <u>copay</u> /office visit for Applied Behavior Analysis; No Charge for Physical, Speech and Occupational Therapy	20% <u>coinsurance</u>	Prior authorization is required for applied behavior analysis (ABA). Services rendered by an approved licensed behavior analyst (LBA) will apply the In-network cost-sharing.
	<u>Skilled nursing care</u>	No Charge	No Charge	Physician certification required. Limited to 120 days per member per calendar year
	<u>Durable medical equipment</u>	No Charge	No Charge	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	Physician certification required. Unlimited visits.
<b>If your child needs dental or eye care</b> For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

## Excluded Services & Other Covered Services:

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

- Cosmetic Surgery
- Dental care (Adult)
- Long term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Acupuncture treatment
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See (<http://www.messa.org>)
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S
- Private-duty nursing

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov) or by calling 1-800-324-6172. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact MESSA by calling 1-800-336-0013.

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

### **Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### **Does this plan meet Minimum Value Standards? Yes**

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

### **Language Access Services: See Addendum**

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

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## About these Coverage Examples:



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

### Peg is Having a Baby

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

■ <b>The plan's overall deductible</b>	\$500
■ <b>Specialist copayment</b>	\$20
■ <b>Hospital (facility) coinsurance</b>	0%
■ <b>Other coinsurance</b>	0%

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$570</b>

### Managing Joe's Type 2 Diabetes

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

■ <b>The plan's overall deductible</b>	\$500
■ <b>Specialist copayment</b>	\$20
■ <b>Hospital (facility) coinsurance</b>	0%
■ <b>Other coinsurance</b>	0%

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$600
<u>What isn't covered</u>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,320</b>

### Mia's Simple Fracture

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

■ <b>The plan's overall deductible</b>	\$500
■ <b>Specialist copayment</b>	\$20
■ <b>Hospital (facility) coinsurance</b>	0%
■ <b>Other coinsurance</b>	0%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
Diagnostic tests (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$550</b>

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or coinsurance, or benefits not otherwise covered.

## Language services

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

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

إذا كنت أنت أو شخص آخر تساعد به حاجة إلى المساعدة، فمن حَقَّكَ الحصول على المساعدة والمعلومات بلغتك بدون أيَّ كلفة للتحدَّث إلى مترجم، اتصل بالرقم المخصَّص الموجود على ظهر بطاقتك MESSA لخدمات أعضاء.

如果您，或是您正在協助的對象，需要協助，您有權利免費已您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的MESSA會員服務電話。

Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ, cần sự giúp đỡ, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, hãy gọi đến số dịch vụ thành viên MESSA trên mặt sau của thẻ.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e shërbimit të anëtarësimit MESSA në anën e pasme të kartës tuaj.

귀하 또는 귀하가 도움을 제공하는 누군가가 도움이 필요한 경우, 귀하는 귀하의 모국어로 무료로 도움과 정보를 제공 받을 권리를 갖고 있습니다. 통역사의 도움을 받으려면 카드 뒷면의 MESSA 회원 서비스 번호로 전화하십시오.

যদি আপনার বা আপনদ সাহায্য কররন এমন কাররা সহায়তার প্রয়োজন হয়, তাহরে ককারণা খরচ ছাড়াই আপনার ভাষায় সহায়তা ও তথ্য পাওয়ার অদিকার ররয়রছ। ককারণা কািভাষীর সারথ্ কখ্া বেরত, আপনার কারডের কপছরন প্ৰিত MESSA সিসয পদররষবার নম্বরর কে করুন।

যদি আপনার বা আপনদ সাহায্য কররন এমন কাররা সহায়তার প্রয়োজন হয়, তাহরে ককারণা খরচ ছাড়াই আপনার ভাষায় সহায়তা ও তথ্য পাওয়ার অদিকার ররয়রছ। ককারণা কািভাষীর সারথ্ কখ্া বেরত, আপনার কারডের কপছরন প্ৰিত MESSA সিসয পদররষবার নম্বরর কে করুন।

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

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

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

Если Вам или лицу, которому Вы помогаете, нужна помощь, то Вы имеете право на бесплатное получение помощи и информации на Вашем языке. Для разговора с переводчиком позвоните по номеру

телефона MESSA отдела обслуживания клиентов, указанному на обратной стороне Вашей карты. Ukoliko je vama ili nekom kome pomažete potrebna pomoć, imate pravo dobiti pomoć i informaciju na vašem jeziku besplatno. Da biste razgovarali sa prevodiocem, pozovite broj za usluge članova MESSA na zadnjoj strani vaše kartice.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang interpreter, tumawag sa numero para sa mga serbisyo sa miyembro ng MESSA na nasa likuran ng iyong card.

## Important disclosure

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

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



# MESSA Choices & 5 Tier RX



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

10% Coinsurance

Coverage for: Individual/Family | Plan Type: PPO



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

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.messa.org](http://www.messa.org) or call MESSA at 1-800-336-0013. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call MESSA at 1-800-336-0013 to request a copy.

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



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /office visit	30% <u>coinsurance</u>	Members 18 years and older have access to Virtual Primary Care visits by a BCBSM selected vendor.
	<u>Specialist</u> visit	\$20 <u>copay</u> /office visit	30% <u>coinsurance</u>	None
	<u>Preventive care/ screening/ immunization</u>	No Charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	May require <u>prior authorization</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.bcbsm.com/druglists">www.bcbsm.com/druglists</a>	Generic drugs	\$10 <u>copay</u> /prescription for retail 34-day supply; \$30 <u>copay</u> /prescription for retail or mail order 90-day supply; <u>deductible</u> does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	Prior authorization, step therapy and quantity limits may apply to select drugs. <u>Preventive</u> drugs covered in full. Your Prescription drug coverage has a separate out-of-pocket limit of \$2,000/\$4,000. Mail order drugs are not covered out-of-network
	Preferred brand-name drugs	\$40 <u>copay</u> /prescription for retail 34-day supply; \$120 <u>copay</u> /prescription for retail or mail order 90-day supply; <u>deductible</u> does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	
	Non-preferred brand-name drugs	\$80 <u>copay</u> /prescription for retail 34-day supply; \$240 <u>copay</u> /prescription for retail or mail order 90-day supply; <u>deductible</u> does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	
	Exclusive Pharmacy Network for Generic and preferred brand-name specialty drugs	20% of the approved amount, but no more than \$150 for each prescription for retail 30-day supply; <u>deductible</u> does not apply	Not covered	Prior authorization is required. <u>Specialty drugs</u> limited to a 15 or 30-day supply
	Exclusive Pharmacy Network for Non-preferred brand-name specialty drugs	20% of the approved amount, but no more than \$300 for each prescription for retail 30-day supply; <u>deductible</u> does not apply	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$50 <u>copay</u> /visit	\$50 <u>copay</u> /visit	<u>Copay</u> waived if admitted or for an accidental injury.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Mileage limits apply
	<u>Urgent care</u>	\$25 <u>copay</u> /visit	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior authorization</u> is required.
	Physician/surgeon fee	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior authorization</u> is required.
If you are pregnant	Office visits	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services <u>cost share</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Physician certification required.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	<u>Habilitation services</u>	\$20 <u>copay</u> /office visit for Applied Behavior Analysis; 10% <u>coinsurance</u> for Physical, Speech and Occupational Therapy	30% <u>coinsurance</u>	Prior authorization is required for applied behavior analysis (ABA). Services rendered by an approved licensed behavior analyst (LBA) will apply the In-network cost-sharing.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Physician certification required. Limited to 120 days per member per calendar year
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	Physician certification required. Unlimited visits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If your child needs dental or eye care</b> For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

## Excluded Services & Other Covered Services:

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

- Cosmetic Surgery
- Dental care (Adult)
- Long term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Acupuncture treatment
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See (<http://www.messa.org>)
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S
- Private-duty nursing

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov) or by calling 1-800-324-6172. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact MESSA by calling 1-800-336-0013.

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

### **Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### **Does this plan meet Minimum Value Standards? Yes**

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

### **Language Access Services: See Addendum**

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

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## About these Coverage Examples:



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

### Peg is Having a Baby

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$20
■ <u>Hospital (facility) coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This **EXAMPLE** event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$900
<u>What isn't covered</u>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,470</b>

### Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$20
■ <u>Hospital (facility) coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This **EXAMPLE** event includes services like:

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$60
<u>What isn't covered</u>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,380</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$20
■ <u>Hospital (facility) coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This **EXAMPLE** event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic tests (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$100
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$650</b>

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or coinsurance, or benefits not otherwise covered.

## Language services

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

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

إذا كنت أنت أو شخص آخر تساعد به حاجة إلى المساعدة، فمن حَقَّكَ الحصول على المساعدة والمعلومات بلغتك بدون أيَّ كلفة للتحدَّث إلى مترجم، اتصل بالرقم المخصَّص الموجود على ظهر بطاقتك MESSA لخدمات أعضاء.

如果您，或是您正在協助的對象，需要協助，您有權利免費已您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的MESSA會員服務電話。

Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ, cần sự giúp đỡ, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, hãy gọi đến số dịch vụ thành viên MESSA trên mặt sau của thẻ.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e shërbimit të anëtarësimit MESSA në anën e pasme të kartës tuaj.

귀하 또는 귀하가 도움을 제공하는 누군가가 도움이 필요한 경우, 귀하는 귀하의 모국어로 무료로 도움과 정보를 제공 받을 권리를 갖고 있습니다. 통역사의 도움을 받으려면 카드 뒷면의 MESSA 회원 서비스 번호로 전화하십시오.

যদি আপনার বা আপনদ সাহায্য কররন এমন কাররা সহায়তার প্রয়োজন হয়, তাহলে ককারণা খরচ ছাড়াই আপনার ভাষায় সহায়তা ও তথ্য পাওয়ার অধিকার ররররর। ককারণা কাভাষীর সারথ কখা বেরত, আপনার কারডের কপছরন প্রিত MESSA সিস্য পদররররর নস্থরর কে করন।

যদি আপনার বা আপনদ সাহায্য কররন এমন কাররা সহায়তার প্রয়োজন হয়, তাহলে ককারণা খরচ ছাড়াই আপনার ভাষায় সহায়তা ও তথ্য পাওয়ার অধিকার ররররর। ককারণা কাভাষীর সারথ কখা বেরত, আপনার কারডের কপছরন প্রিত MESSA সিস্য পদররররর নস্থরর কে করন।

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

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

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

Если Вам или лицу, которому Вы помогаете, нужна помощь, то Вы имеете право на бесплатное получение помощи и информации на Вашем языке. Для разговора с переводчиком позвоните по номеру

телефона MESSA отдела обслуживания клиентов, указанному на обратной стороне Вашей карты. Ukoliko je vama ili nekom kome pomažete potrebna pomoć, imate pravo dobiti pomoć i informaciju na vašem jeziku besplatno. Da biste razgovarali sa prevodiocem, pozovite broj za usluge članova MESSA na zadnjoj strani vaše kartice.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang interpreter, tumawag sa numero para sa mga serbisyo sa miyembro ng MESSA na nasa likuran ng iyong card.

## Important disclosure

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

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



# MESSA ABC & ABC 5 Tier RX



Plan 2.5

Coverage for: Individual/Family | Plan Type: PPO

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



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

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.messa.org](http://www.messa.org) or call MESSA at 1-800-336-0013. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call MESSA at 1-800-336-0013 to request a copy.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall <u>deductible</u> ?	\$2,500 Individual/ \$5,000 Family	\$5,000 Individual/ \$10,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .		This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at ( <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> ).
Are there other <u>deductibles</u> for specific services?	No.		You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? (May include a <u>coinsurance</u> maximum)	\$4,500 Individual/ \$8,500 Family	\$9,000 Individual/ \$18,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, <u>balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this <u>plan</u> doesn't cover.		Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. For a list of <u>network providers</u> see ( <a href="http://www.messa.org">http://www.messa.org</a> ) or call MESSA at 800-336-0013		This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.		You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	No Charge	20% <u>coinsurance</u>	Members 18 years and older have access to Virtual Primary Care visits by a BCBSM selected vendor.
	<u>Specialist</u> visit	No Charge	20% <u>coinsurance</u>	None
	<u>Preventive care/ screening/ immunization</u>	No Charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No Charge	20% <u>coinsurance</u>	May require <u>prior authorization</u> .
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.bcbsm.com/druglists">www.bcbsm.com/druglists</a>	Generic drugs	\$10 <u>copay</u> /prescription for retail 34-day supply; \$30 <u>copay</u> /prescription for retail and mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	Prior <u>authorization</u> , step therapy and quantity limits may apply to select drugs. <u>Preventive</u> drugs covered in full. Mail order drugs are not covered out-of-network
	Preferred brand-name drugs	\$40 <u>copay</u> /prescription for retail 34-day supply; \$120 <u>copay</u> /prescription for retail and mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	
	Non-preferred brand-name drugs	\$80 <u>copay</u> /prescription for retail 34-day supply; \$240 <u>copay</u> /prescription for retail and mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	
	Exclusive Pharmacy Network for Generic and preferred brand-name specialty drugs	20% of the approved amount, but no more than \$150 for each prescription for retail 30-day supply	Not covered	<u>Prior authorization</u> is required. <u>Specialty drugs</u> limited to a 15 or 30-day supply
	Exclusive Pharmacy Network for Non-preferred brand-name specialty drugs	20% of the approved amount, but no more than \$300 for each prescription for retail 30-day supply	Not covered	<u>Prior authorization</u> is required. <u>Specialty drugs</u> limited to a 15 or 30-day supply

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% <u>coinsurance</u>	None
	Physician/surgeon fees	No Charge	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	No Charge	No Charge	None
	<u>Emergency medical transportation</u>	No Charge	No Charge	Mileage limits apply
	<u>Urgent care</u>	No Charge	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% <u>coinsurance</u>	<u>Prior authorization</u> is required.
	Physician/surgeon fee	No Charge	20% <u>coinsurance</u>	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	No Charge	20% <u>coinsurance</u>	None
	Inpatient services	No Charge	20% <u>coinsurance</u>	<u>Prior authorization</u> is required.
If you are pregnant	Office visits	No Charge; <u>deductible</u> does not apply	20% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services <u>cost share</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	No Charge	20% <u>coinsurance</u>	None
	Childbirth/delivery facility services	No Charge	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No Charge	No Charge	Physician certification required.
	<u>Rehabilitation services</u>	No Charge	20% <u>coinsurance</u>	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	<u>Habilitation services</u>	No Charge for Applied Behavior Analysis; No Charge for Physical, Speech and Occupational Therapy	20% <u>coinsurance</u>	Prior authorization is required for applied behavior analysis (ABA). Services rendered by an approved licensed behavior analyst (LBA) will apply the In-network cost-sharing.
	<u>Skilled nursing care</u>	No Charge	No Charge	Physician certification required. Limited to 120 days per member per calendar year
	<u>Durable medical equipment</u>	No Charge	No Charge	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	<u>Hospice services</u>	No Charge	No Charge	Physician certification required. Unlimited visits.
<b>If your child needs dental or eye care</b> For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

## Excluded Services & Other Covered Services:

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

- Cosmetic Surgery
- Dental care (Adult)
- Long term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Acupuncture treatment
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See (<http://www.messa.org>)
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S
- Private-duty nursing

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov) or by calling 1-800-324-6172. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact MESSA by calling 1-800-336-0013.

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

### **Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### **Does this plan meet Minimum Value Standards? Yes**

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

### **Language Access Services: See Addendum**

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

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## About these Coverage Examples:



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

### Peg is Having a Baby

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

■ <b>The plan's overall deductible</b>	<b>\$2,500</b>
■ <b>Specialist coinsurance</b>	<b>0%</b>
■ <b>Hospital (facility) coinsurance</b>	<b>0%</b>
■ <b>Other coinsurance</b>	<b>0%</b>

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,570</b>

### Managing Joe's Type 2 Diabetes

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

■ <b>The plan's overall deductible</b>	<b>\$2,500</b>
■ <b>Specialist coinsurance</b>	<b>0%</b>
■ <b>Hospital (facility) coinsurance</b>	<b>0%</b>
■ <b>Other coinsurance</b>	<b>0%</b>

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,920</b>

### Mia's Simple Fracture

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

■ <b>The plan's overall deductible</b>	<b>\$2,500</b>
■ <b>Specialist coinsurance</b>	<b>0%</b>
■ <b>Hospital (facility) coinsurance</b>	<b>0%</b>
■ <b>Other coinsurance</b>	<b>0%</b>

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
Diagnostic tests (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,500</b>

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or coinsurance, or benefits not otherwise covered.

## Language services

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

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

إذا كنت أنت أو شخص آخر تساعد به حاجة إلى المساعدة، فمن حَقَّكَ الحصول على المساعدة والمعلومات بلغتك بدون أيَّ كلفة للتحدَّث إلى مترجم، اتصل بالرقم المخصَّص الموجود على ظهر بطاقتك MESSA لخدمات أعضاء.

如果您，或是您正在協助的對象，需要協助，您有權利免費已您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的MESSA會員服務電話。

Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ, cần sự giúp đỡ, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, hãy gọi đến số dịch vụ thành viên MESSA trên mặt sau của thẻ.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e shërbimit të anëtarësimit MESSA në anën e pasme të kartës tuaj.

귀하 또는 귀하가 도움을 제공하는 누군가가 도움이 필요한 경우, 귀하는 귀하의 모국어로 무료로 도움과 정보를 제공 받을 권리를 갖고 있습니다. 통역사의 도움을 받으려면 카드 뒷면의 MESSA 회원 서비스 번호로 전화하십시오.

যদি আপনার বা আপনদ সাহায্য কররন এমন কাররা সহায়তার প্রয়োজন হয়, তাহলে ককারণা খরচ ছাড়াই আপনার ভাষায় সহায়তা ও তথ্য পাওয়ার অধিকার ররররর। ককারণা কািভাষীর সারথ কখা বেরত, আপনার কারডের কপছরন প্ৰিত MESSA সিসয পদররররর নম্বরর কে কররন।

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

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

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

Если Вам или лицу, которому Вы помогаете, нужна помощь, то Вы имеете право на бесплатное получение помощи и информации на Вашем языке. Для разговора с переводчиком позвоните по номеру

телефона MESSA отдела обслуживания клиентов, указанному на обратной стороне Вашей карты. Ukoliko je vama ili nekom kome pomažete potrebna pomoć, imate pravo dobiti pomoć i informaciju na vašem jeziku besplatno. Da biste razgovarali sa prevodiocem, pozovite broj za usluge članova MESSA na zadnjoj strani vaše kartice.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang interpreter, tumawag sa numero para sa mga serbisyo sa miyembro ng MESSA na nasa likuran ng iyong card.

## Important disclosure

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

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

# MESSA Dental plan highlights



MESSA  
1475 Kendale Blvd. PO Box 2560  
East Lansing, Michigan 48826-2560  
517-332-2581 • 800-292-4910

**Effective Date: 01/01/2026**

**MESSA Account: Pinconning Area Schools**

**Employee Group: Teacher**

**Group/Subgroup: 06398-0017**

MESSA dental plans are underwritten and administered by Delta Dental of Michigan, a non-profit dental care corporation known for its high quality dental programs. Delta Dental contracts with dentists throughout the U.S. to provide high quality care and 90% of Michigan dentists are in the Delta Dental provider network. MESSA members can easily locate Delta Dental contracting providers by visiting [messa.org](http://messa.org) and using the provider directory search provided by Delta Dental.

Plan Features			
Diagnostic & Preventive Services 100%	Basic Services 90%	Major Services 90%	Orthodontics 90%
<ul style="list-style-type: none"> <li>• Radiographs (x-rays)*</li> <li>• Oral Examination</li> <li>• Prophylaxes</li> <li>• Topical Fluoride**</li> <li>• Brush Biopsy</li> <li>• Emergency Pallative</li> <li>• 2 Cleanings in 12 Months</li> </ul> <p>* Bitewing x-rays are payable once in any period of 12 consecutive months. Full mouth panograph is payable once in 5 years.</p> <p>** Fluoride treatments are payable twice in any period of 12 consecutive months for people up to age 19.</p> <p><b>Rider</b> (If neither box below is checked, you do not have this coverage.)</p> <p><input type="checkbox"/> 3 Cleanings in 12 Months</p> <p><input type="checkbox"/> 4 Cleanings in 12 Months</p>	<ul style="list-style-type: none"> <li>• Restorative</li> <li>• Crowns*</li> <li>• Oral Surgery</li> <li>• Endodontic Services — treatment for diseased or damaged nerves.</li> <li>• Periodontic Services — treatment for diseases of the gum and teeth-supporting structures.</li> </ul> <p>* Payable once in any 5-year period on the same tooth.</p> <p><b>Rider</b> (If the box below is not checked, you do not have this coverage.)</p> <p><input checked="" type="checkbox"/> Sealants: payable on occlusal surface of first permanent molars for patients up to age 9 and for second permanent molars for patients up to age 14 that are free from caries and restorations.</p>	<ul style="list-style-type: none"> <li>• Procedures for the construction of fixed bridgework, endosteal implants, partial and complete dentures.</li> <li>• Payable once in any 5-year period for the same appliances.</li> </ul>	<ul style="list-style-type: none"> <li>• Necessary treatment and procedures required for the correction of abnormal bite.</li> <li>• Orthodontic exam, radiographs and extractions are covered under Diagnostic &amp; Preventive Services and Basic Services.</li> </ul> <p><b>Rider</b> (If the box below is not checked, you do not have this coverage.)</p> <p><input type="checkbox"/> Adult orthodontics: removes the age 19 restriction on Orthodontics coverage.</p>
<p><b>\$2,500</b> annual maximum per person <b>Diagnostic &amp; Preventive Services, Basic Services, and Major Services</b></p>			<p><b>\$3,500</b> lifetime maximum per person <b>Orthodontics</b></p>

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

# VSP 3 Plus P 250CL Benefits



1475 Kendale Blvd. PO Box 2560  
 East Lansing, Michigan 48826-2560  
 517-332-2581 • 800-292-4910

**Effective Date: 1/1/2026**

**MESSA Account: Pinconning Area Schools**

**Employee Group: Teacher**

## In-network providers

Most eye doctors are in VSP's Choice network. Staying in-network makes sure you get the most value from your benefits and limits your out-of-pocket costs. In-network doctors bill VSP directly as a convenience to you. A directory of Choice network doctors is available at [messa.org](http://messa.org) or [vsp.com](http://vsp.com). Call VSP member services at 800-877-7195 for assistance.

## Out-of-network providers

(Maximum reimbursement to patient)

If you choose to see a doctor who is not in the VSP Choice network, your out-of-pocket costs will likely be higher and you must submit the itemized receipts to VSP for reimbursement. For more information, visit [vsp.com](http://vsp.com) or call VSP member services at 800-877-7195.

Benefit	In-network provider	Out-of-network provider maximum allowance
<b>Examination</b>		
Optometrist	No copayment	\$35
Ophthalmologist	No copayment	\$45
<b>Contact lenses (includes contact lens examination) *</b>		
Elective lenses to improve vision	\$250 allowance	\$150
Medically necessary - <i>to correct keratoconus, irregular astigmatism, irregular corneal curvature or vision to 20/70 in the better eye</i>	MESSA pays 100% of the approved amount	\$200
<b>Eyeglass frames</b>	\$130 allowance	\$66
<b>Eyeglass lenses</b>		
Single vision	MESSA pays 100% of the approved amount	\$38
Bifocal		\$60
Trifocal		\$72
Lenticular		\$108
<b>Eyeglass lens enhancements</b>		
Rose #1 or #2 tint	MESSA pays 100% of the approved amount	Member must pay the difference between the approved amount and the provider charge
Rimless		
Oversize		
Blended		
Photochromic		
Progressive		
<b>Tinted</b>		
Single vision	MESSA pays 100% of the approved amount	\$42
Bifocal		\$70
Trifocal		\$84
Lenticular		\$118
<b>Polarized</b>		
Single vision	MESSA pays 100% of the approved amount	\$56
Bifocal		\$90
Trifocal		\$110
Lenticular		\$138

\* The cost of the eye exam is covered separately and does not count against the contact lens allowance.

# MESSA Group Term Life Insurance plan highlights

Underwritten by Life Insurance Company of North America



**MESSA**

1475 Kendale Blvd. PO Box 2560  
East Lansing, Michigan 48826-2560  
517-332-2581 • 800-292-4910

**Effective Date: 01/01/2026**

**Account: Pinconning Area Schools**

**Employee Group: Teacher**

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

Plan features	Definition	Your Coverage
<b>Group Term Life Insurance</b>	The amount of your Group Term Life Insurance coverage.	\$40,000
<b>Group AD&amp;D Insurance</b>	The amount of your Accidental Death and Dismemberment (AD&D) coverage.	\$40,000
<b>Group Dependent Term Life Insurance: SPOUSE</b>	This provides a life benefit equal to 50% of the member's benefit (not to exceed \$25,000) for the spouse and does not contain AD&D benefits.	N/A
<b>Group Dependent Term Life Insurance: CHILD(REN)</b>	This provides a life benefit equal to 25% of the member's benefit (not to exceed \$12,500) for all eligible children and does not contain AD&D benefits.	N/A

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

# MESSA Group LTD Plan Benefit Highlights

Underwritten by Life Insurance Company of North America



**MESSA**

1475 Kendale Blvd. PO Box 2560  
East Lansing, Michigan 48826-2560  
517-332-2581 • 800-292-4910

**Effective Date: 01/01/2026**

**Account: Pinconning Area Schools**

**Employee Group: Teacher**

Long Term Disability (LTD) insurance provides benefits at a percentage of a member's salary in the event of total disability. Benefits begin after the satisfaction of a waiting period and continue as long as the member remains totally disabled as described under "Maximum Benefit Period" in the LTD certificate booklet.

*This is a brief summary of your coverage available under MESSA's Group LTD insurance. Refer to the actual certificate booklet for complete information.*

Plan Features	Definition	Your Coverage
<b>Pre-Existing Conditions</b>	Medical conditions for which the advice or treatment was received prior to effective date of coverage are included. However, doctor-verified disabilities in effect prior to the effective date would be excluded.	Waived
<b>Waiting Period</b>	<i>Calendar Day (CD):</i> The waiting period is based on actual calendar days. <i>Work Day (WD):</i> The waiting period is based on the consecutive number of contracted work days. <i>Modified Fill (MF):</i> Benefits begin on the latter of exhaustion of sick time/ bank or the specified number of calendar/work day waiting period. <i>Straight Wait (SW):</i> Benefits begin after the specified number of calendar/ work day waiting period.	90 CDMF
<b>Benefit Level</b>	Percent of covered salary.	50%
<b>Maximum Benefit Level</b>	Monthly benefit up to the maximum amount bargained.	\$3,500
<b>Minimum Maximum Benefit</b>	There is a minimum monthly benefit of 5% of the gross monthly benefit or \$50, whichever is greater, after all offsets are applied, not to exceed the maximum monthly benefit.	5%
<b>Offsets</b>	Benefits are reduced by any income the employee receives or is entitled to receive such as vacation pay, salary continuation, workers' compensation, full auto wage loss benefit, any employer-paid group plan, retirement benefits you receive from your employer's retirement or pension plan, including Michigan Public School Employees' Retirement System (MPSERS), short-term disability, and others.	
<b>Social Security Offsets</b>	<i>Primary:</i> Social security retirement and social security disability are offsets. <i>Family:</i> Any social security disability benefits received by the employee's family due to the employee's disability is an offset.	Family
<b>Freeze on Offsets</b>	Monthly disability benefits will not be reduced because of automatic, statutory or general cost of living increases in income from other sources after MESSA's initial benefit determination for each specified offset has been made. The exception to this is an unsuccessful return to work with increased salary, social security and retirement cost of living.	No
<b>COLA</b>	An employee's benefit may be increased while on claim due to increase in the cost of living. The increase is based on changes in the Consumer Price Index as of January 1 each year and is payable on the anniversary of the commencement of benefit payment. There is a maximum annual increase of 3%.	No
<b>Own Occupation Maximum Benefit Period</b>	Disability benefits may be payable during continuous disability. After the own occupation period, a member must be unable to perform any occupation for which he/she is qualified by training, experience or education. Benefits may be payable up to age 65. For benefits commencing at or after age 60, please see your benefit schedule.	2 Years
<b>Mental / Nervous Conditions</b>	These conditions are covered as any other illness unless you have a 2-year aggregate limitation.	2-year limitation
<b>Alcoholism / Drug Abuse</b>	These conditions are covered as any other illness unless you have a 2-year aggregate limitation.	2-year limitation

For additional information please call MESSA's Disability Department at 800-247-6951.