



MESSA Balance+ & Balance+ RX
PPO

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 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 deductible?	\$1,650 Individual/ \$3,300 Family	\$3,300 Individual/ \$6,600 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at (https://www.healthcare.gov/coverage/preventive-care-benefits/).
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)	\$4,050 Individual/ \$8,100 Family	\$8,100 Individual/ \$16,200 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of network providers see (http://www.messa.org) or call MESSA at 800-336-0013		This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.		You can see the specialist you choose without a referral.



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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /office visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Members 18 years and older have access to Virtual Primary Care visits by a BCBSM selected vendor.
	Specialist visit	\$50 <u>copay</u> /office visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	Preventive care/ <u>screening</u> / immunization	No Charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (X-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <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)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsm.com/druglists	Generic or prescribed over-the-counter drugs	\$10 <u>copay/prescription</u> for retail 34-day supply; \$30 <u>copay/prescription</u> for 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. Preventive drugs covered in full. A 90-day supply of prescription drugs is not payable at a retail pharmacy. A 90-day supply is only payable at a participating mail order pharmacy.
	Preferred brand-name drugs	\$40 <u>copay/prescription</u> for retail 34-day supply; \$120 <u>copay/prescription</u> for 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/prescription</u> for retail 34-day supply; \$240 <u>copay/prescription</u> for mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	
	Generic and preferred brand-name specialty Drugs	20% <u>coinsurance</u> of the approved amount, but no more than \$150 <u>copay/prescription</u> for retail or mail order 30-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	
If you have outpatient surgery	Nonpreferred brand-name specialty drugs	20% <u>coinsurance</u> of the approved amount, but no more than \$300 <u>copay/prescription</u> for retail or mail order 30-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. Preventive drugs covered in full. 90-day supply not covered out of network.
	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$200 <u>copay/visit</u> ; <u>deductible</u> does not apply	Copay waived if admitted or for an accidental injury. Mileage limits apply
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Urgent care</u>	\$50 <u>copay/visit</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u>	
	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you have a hospital stay	Physician/surgeon fee	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior <u>authorization</u> is required 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 behavioral health services (mental health and substance use disorder)	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior authorization</u> is required.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Home health care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Physician certification required.
	Rehabilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Applied behavior analysis (ABA) treatment for Autism - when rendered by a Licensed Behavior Analyst (LBA) - subject to <u>prior authorization</u> .
If you need help recovering or have other special health needs	Skilled nursing care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Physician certification required. Limited to 120 days per member per calendar year
	Durable medical equipment	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Physician certification required. Unlimited visits.
	Children's eye exam	Not covered	Not covered	None
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	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)
- Hearing aids
- 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>)
- Fertility 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, 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.ccio.cms.gov or by calling 1-800-324-6172. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

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

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

About these Coverage Examples:



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

Peg is Having a Baby

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

- **The plan's overall deductible** **\$1,650**
- **Specialist copayment** **\$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:

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

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

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,650
Copayments	\$10
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,920

Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **\$1,650**
- **Specialist copayment** **\$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:

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

Total Example Cost **\$5,600**

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,650
Copayments	\$600
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,370

Mia's Simple Fracture

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

- **The plan's overall deductible** **\$1,650**
- **Specialist copayment** **\$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:

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

Total Example Cost **\$2,800**

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,650
Copayments	\$100
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,790

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.

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

Language services

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

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

إذا كنت أنت أو شخص آخر تحتاج مساعدة في اللغة، فإن حقا الحصول على المساعدة والمعلومات بلغتك دون أي تكلفة. للتحدث مع مترجم، اتصل بالرقم المخصص للعضوات MESSA على ظهر بطاقة العضوات.

如果您，或是您在協助的對象，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.

Mese ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merreni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përktshës, 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.

동역사의 도움을 받으려면 카드 뒷면의 MESSA 회원 서비스 번호로 전화하십시오.

यदि आपनात वा आपनात साहायस करारन प्रमल काररनत सहायतार प्ररनातल सन्, तारर करारनत धररत बातुरर आपनार तारनत सहायतत त तथत पाठनार अतारर कररनत। करारनत कतारनत सारथ कथता कररत, आपनार काररतुत करररनत तुर MESSA तिससत सारररनतार नारररत कर कररनत।

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 kostenloser Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer der MESSA-Mitgliedsbetreuung 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、またはお客様の方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出来ます。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

800.336.0013 or TTY 888.445.5614.

телефона MESSA отдела обслуживания клиентов, указанному на обратной стороне Вашей карты. Уколько је вама или неком коме помажете потребна помоћ, имате право добити помоћ Информацију на вашем језику бесплатно. Да бисте разговарали са преводиоцем, позовите број за улуге чланова MESSA на задњој страни ваше карте.

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

Important disclosure

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

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

You can also file a civil rights complaint with the Office for Civil Rights on the web at OCCRCComplaint@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 OCCRCComplaint@hhs.gov.