

### **Essentials by MESSA**



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

PPO

Coverage for: Individual/Family | Plan Type: PPO

the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. 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

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. 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-

Important Questions	vsn	vers	Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	\$375 Individual/ \$750 Family	\$750 Individual/ \$1,500 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 Yes. Preventive care services are covered you meet your deductible.	Yes. <u>Preventive care</u> services ar before you meet your <u>deductible</u>	services are covered deductible.	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</u> <u>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 deductibles for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan?</u> (May include a <u>coinsurance</u> maximum)	\$9,200 Individual/ \$18,400 Family	\$18,025 Individual/ \$36,050 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-</u> pocket limit?	Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn't cover.	lling charges, any I health care this	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 <u>network providers</u> see ( <u>http://www.messa.org</u> ) or call MESSA at 800-336-0013	<u>ork providers</u> see g) or call MESSA at	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 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  If you visit a health care  provider's office or clinic	Services You May Need Primary care visit to treat an injury or illness Specialist visit Preventive care/	In-Network Provider (You will pay the least) \$25 copay/office visit \$50 copay/office visit	Out-of-Network Provider (You will pay the most)  40% coinsurance  40% coinsurance	Members 18 years and older have access to Virtual Primary Care visits by a BCBSM selected vendor.  None  You may have to pay for services that aren't
<u>provider's</u> office or clinic	Preventive care/ screening/ 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 preventive. Then check what your plan will pay for.
	Diagnostic test (x-ray, blood work)	20% <u>coinsurance</u>	40% coinsurance	None
ii you ilave a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	May require prior authorization

	If you have outpatient surgery		If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.messa.org		Common Medical Event
Physician/surgeon fees	Facility fee (e.g., ambulatory surgery center)	Non-preferred brand- name drugs	Preferred brand-name drugs	Generic or prescribed over-the-counter drugs	Services You May Need
20% coinsurance	20% <u>coinsurance</u>	20% coinsurance of the approved amount, but not less than \$60 copay/prescription or more than \$100 copay/prescription for retail 34-day supply; 20% coinsurance of the approved amount, but not less than \$180 copay/prescription or more than \$300 copay/prescription for retail and mail order 90-day supply; deductible does not apply	20% coinsurance of the approved amount, but not less than \$40 copay/prescription or more than \$80 copay/prescription for retail 34-day supply; 20% coinsurance of the approved amount, but not less than \$120 copay/prescription or more than \$240 copay/prescription for retail and mail order 90-day supply; deductible does not apply	\$10 copay/prescription for retail 34-day supply; \$30 copay/prescription for retail and mail order 90-day supply; deductible does not apply	What You have the least (You will pay the least)
40% coinsurance	40% coinsurance	In-Network <u>copay</u> plus an additional 25% of the approved amount; <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	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	What You Will Pay  der Out-of-Network Provider east) (You will pay the most)
None	None		Prior authorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of network. Mail order drugs are not covered out-of-network.		Limitations, Exceptions, & Other Important Information

		What Yo	What You Will Pay	
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
	Emergency room care	\$200 <u>copay</u> /visit	\$200 <u>copay</u> /visit	Copay waived if admitted or for an accidental injury.
If you need immediate medical attention	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Mileage limits apply
	<u>Urgent care</u>	\$50 copay/visit	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Prior authorization is required
	Physician/surgeon fee	20% coinsurance	40% coinsurance	None
If you need behavioral	Outpatient services	20% coinsurance	40% coinsurance	None
health services (mental health and substance use disorder)	Inpatient services	20% <u>coinsurance</u>	40% coinsurance	Prior authorization is required.
If you are pregnant	Office visits	No Charge; <u>deductible</u> does not apply	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 cost share may apply. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None

	pediatric vision or dental, contact your plan administrator	eye care  For more information on	If your child needs dental or Children's eye exam			needs	If you need help recovering			Common Medical Event	
	Children's dental check- up	Children's glasses	Children's eye exam	Hospice services	<u>Durable medical</u> <u>equipment</u>	Skilled nursing care	Habilitation services	Rehabilitation services	Home health care	Services You May Need	
	Not covered	Not covered	Not covered	No Charge; <u>deductible</u> does not apply	20% <u>coinsurance</u>	20% coinsurance	20% coinsurance	20% <u>coinsurance</u>	20% coinsurance	In-Network Provider (You will pay the least)	What Y
	Not covered	Not covered	Not covered	No Charge; <u>deductible</u> does not apply	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance	20% coinsurance	Out-of-Network Provider (You will pay the most)	What You Will Pay
5 of 9	None	None	None	Physician certification required. Unlimited visits.	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.	Physician certification required. Limited to 120 days per member per calendar year	Applied behavior analysis (ABA) treatment for Autism - when rendered by a Licensed Behavior Analyst (LBA) - subject to prior authorization.	Physical, Speech and Occupational Therapy is limited to a combined maximum of 30 visits per member, per calendar year.	Physician certification required.	Information  Information	Limitations Reportions & Other Important

## **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.)

- Acupuncture treatment
- Bariatric surgery
- Cosmetic Surgery

- Dental care (Adult)
- Hearing aids

Long term care

- Routine eye care (Adult)
- Weight loss programs

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

Chiropractic care

Coverage provided outside the United States.

See (http://www.messa.org)

- Infertility treatment
- Non-emergency care when traveling outside the
  - Private-duty nursing
- Routine foot care

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 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 or by 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 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: more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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 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 1-800-336-0013.

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

## 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

of specific EHB categories, for example prescription drugs, through another carrier.) 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 (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 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

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

### About these Coverage Examples:



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 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 health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

The total Peg would pay is \$2,345	Limits or exclusions \$60	What isn't covered	Coinsurance \$1,900	Copayments \$10	Deductibles \$375	Cost Sharing	In this example, Peg would pay:	Total Example Cost \$12,700	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)	The <u>plan's</u> overall <u>deductible</u> \$375  Specialist <u>copayment</u> \$50  Hospital (facility) <u>coinsurance</u> 20%  Other <u>coinsurance</u> 20%	Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)
The total Joe would pay is	Limits or exclusions	What isn't covered	Coinsurance	Copayments	Deductibles	Cost Sharing	In this example, Joe would pay:	Total Example Cost	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)	<ul> <li>The <u>plan's</u> overall <u>deductible</u></li> <li><u>Specialist copayment</u></li> <li>Hospital (facility) <u>coinsurance</u></li> <li>Other <u>coinsurance</u></li> </ul>	Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)
\$1,495	\$20		\$800	\$300	\$375			\$5,600	ike:	\$375 \$50 20% 20%	es f
The total Mia would pay is	Limits or exclusions	What isn't covered	Coinsurance	Copayments	Deductibles	<u>Cost Sharing</u>	In this example, Mia would pay:	Total Example Cost	This EXAMPLE event includes services like: Emergency room care (including medical supplies) Diagnostic tests (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)	<ul> <li>The <u>plan's</u> overall <u>deductible</u></li> <li><u>Specialist copayment</u></li> <li>Hospital (facility) <u>coinsurance</u></li> <li>Other <u>coinsurance</u></li> </ul>	Mia's Simple Fracture (in-network emergency room visit and follow up care)
\$775	\$0		\$300	\$100	\$375			\$2,800	s like:	\$375 \$50 20% 20%	and

deductible, copayments, or coinsurance, or benefits not otherwise covered (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 If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement

#### 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 تمفص أهر تساعده بعاجة إلى العسائدة، فمن حقافه المعسول على العسائدة والمعلومات بلغتك بدون أي كافة بالتحلات إلى منزجم العسل بالرقم المخصتص منزجم العسل بالرقم المخصتص الموجود على ظهر بطاقاته 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。要治詢一位翻譯員,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. Đế 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.

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যদি অপনার বা অপদন সাহায়র কররন এমন করে। সহায়তার প্ররাজন হয়, তাহরে ককারনা থরচ হাড়াই সহায়তার প্ররাজন হয়, তাহরে ককারনা থরচ হাড়াই অপনার তাহায় সহায়তা ও ভব্য পাওয়ার অদিকার ররেয়রছ। ককারনা কিভানীর সার্থ কম্বা বেরত, আপনার কার্ডের কপ্রর প্রিত্ত MESSA সিস্ম পদর্বযার নম্বর (ক কম্বন।

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

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

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

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

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

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

#### Important disclosure

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

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

#### GeneralCounsel@messa.org.

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