Blue Cross Blue Shield of Michigan

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

MESSA ABC & ABC RX

Plan 1 w / Mandatory Mail

MESSA

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?	$1,500 Individual/ $3,000 Family	$3,000 Individual/ $6,000 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 policy, the overall family deductible must be met before the plan begins to pay.
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)	$2,500 Individual/ $5,000 Family	$5,000 Individual/ $10,000 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges,deductible, 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	No Charge	20% coinsurance	None
	Specialist visit	No Charge	20% coinsurance	None
	Preventive care/ screening/ immunization	No Charge; deductible 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.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance	May require preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.messa.org	Generic or prescribed over-the-counter drugs	$10 copay/prescription for retail 34-day supply; $20 copay/prescription for mail order 90 day supply	In-Network copay plus an additional 25% of the approved amount	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. Mail order drugs are not covered out-of-network.
	Preferred brand-name drugs	$40 copay/prescription for retail 34-day supply; $80 copay/prescription for mail order 90 day supply	In-Network copay plus an additional 25% of the approved amount	
	Non-preferred brand-name drugs	$40 copay/prescription for retail 34-day supply; $80 copay/prescription for mail order 90 day supply	In-Network copay plus an additional 25% of the approved amount	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% coinsurance	None
	Physician/surgeon fees	No Charge	20% coinsurance	None
If you need immediate medical attention	Emergency room care	No Charge	No Charge	None
	Emergency medical transportation	No Charge	No Charge	Mileage limits apply
	Urgent care	No Charge	20% coinsurance	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)	No Charge	20% coinsurance	Preauthorization is required
	Physician/surgeon fee	No Charge	20% coinsurance	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	No Charge	20% coinsurance	None
	Inpatient services	No Charge	20% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	No Charge; deductible does not apply	20% coinsurance	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	No Charge	20% coinsurance	None
	Childbirth/delivery facility services	No Charge	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Physician certification required.
	Rehabilitation services	No Charge	20% coinsurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	No Charge	20% coinsurance	Applied behavior analysis (ABA) treatment for Autism - when rendered by a Licensed Behavior Analyst (LBA) - subject to preauthorization.
	Skilled nursing care	No Charge	No Charge	Physician certification required. Limited to 120 days per member per calendar year
	Durable medical equipment	No Charge	No Charge	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge	No Charge	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)	
If your child needs dental or eye care 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, 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 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	**$1,500**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,570**

Managing Joe's Type 2 Diabetes
(a year of routine in network care of a well controlled condition)

The plan's overall deductible	**$1,500**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

Mia's Simple Fracture
(in network emergency room visit and follow up care)

The plan's overall deductible	**$1,500**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,510**

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.

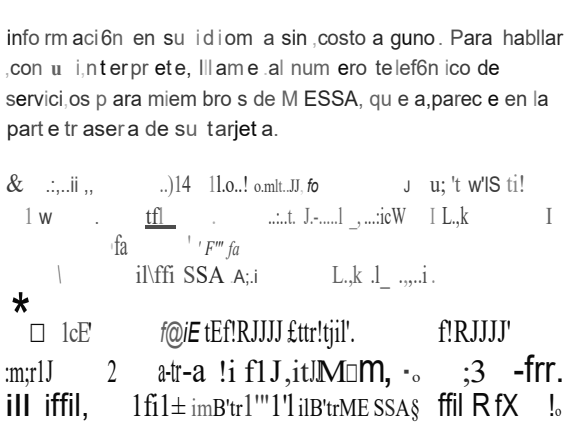
The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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.

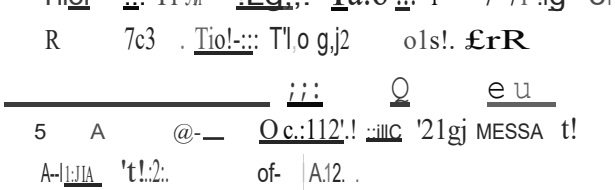
Si usted, o alguien a quien usted estii ayudando, necesita asistencia, tiene derecho a obtener ayuda e

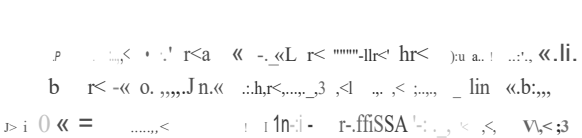
informaci6n en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telef6nico de servicios para miembros de MESSA, que aparece en la parte trasera de su tarjeta.

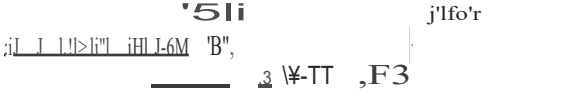


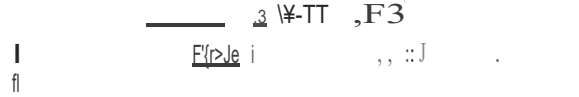
Neu quy vi ho cai, do mat quy vi dang giup do, dinh S'il giup do, quy vi c6 quyen dtrQ'C tr(?i gi up va nh n thong tin b ng ngon ngU" cua quy vi mi n phi. E>e n6i, chuy n vO'i m q,tt hon g d,chvie,n hay gqi den SO d jch vi,i th anh vien MESSA tren m :t sau cua the.

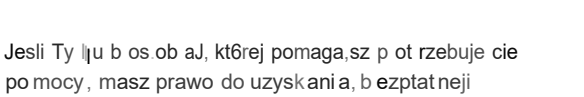
Ne.se ju ose dikush qe po ndih m oni, ka nevoje per a,sistence, keni te drejte te merm i ndihme dhe informacion falas ne gjuhen tuaj. Per te fo lur me nje perl<t:hy es , telefo noni numrin e sherbimit te an etares imit MESSA ne anen e pasm e te kartes · u aji.





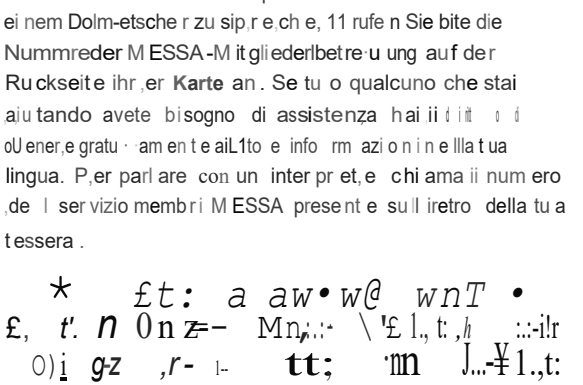


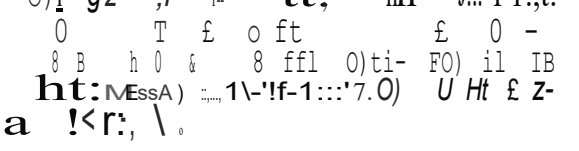




Jesli Ty lub os.ob aJ, kt6rej pomaga,sz p ot rzebuje cie po mocy, masz prawo do uzyskania, b ezptat neji info rm acji i po mo cy we wtasny m ji:z yku. Aby poroz mawia,c z t tu maczem , zad zwo.n pod ru 1m er d ziatu obstugi czto n kow MESSA w sb m m y na odwr ocie Twojej kart y.

falls Sie oder jemand, dem Sie helfen, Unte,rstu tztm g b en otigen, haben Si e d'as Rec ht kostenlose H il fe und 1:nfo rm at ionen in Ihr er Sprac he zu erlhalt en . Um mit ei nem Dolm-etsche r zu sip,r e,ch e, 11 rufe n Sie bite die Nummreder M ESSA-M itgliederlbetre·u ung auf der Ruckseite ihr ,er Karte an . Se tu o qualcuno che stai ,aiutando avete bisogno di assistenza, hai ii d i t o d oUener,e gratu · am en t e aiL1to e info rm azio n i n e llla t ua lingua. P,er parl are con un inter pr et, e chi ama ii num ero ,de l servizio membri M ESSA present e su ll iretro della tu a tessera .





Tenedpo Ha M ES.SA OT,I]leJla 0 6 CJ1ym.t BaH Mi:l KJil '1eftTOB, yKa 3a ,HOMY Ha, o6paTH,OH cropo He Ba weCt 11aPTbl. Ukoliko j e vama illi n ekom kome pomazet e pot ;rebna, p omoc, imat e pravo ,dobiti pomo c l in form acij u na va,sem jez.iku h esp latno. Da biste razgovara li sa prevodiocem, pozovite brnj .za u lsuge i:l ano1'1Ja M ESSA na zadnjoj st,rani vase kart,ice.

Ktm g ikaw, o ang iyong tinutuhm gan, ay nainganga ilanga n ng tulo ng, may karapa,tan kan g

m akakuha ng tu long at imporm asyo n sa iy on g wika nang w alang gastos. Upang m akausap ang isang interpre·t e r, tum aw ag s.a num ero para sa, m.gaserbisyo sa miiYembro ngM ESSA na nasa likuran ng iyong card.

Important disclosure

MESSA and Blue Cross Blue Shield of Michigan, (BCBSM:) comply with federal ,civil right s laws and do not ,discriminate on the ba,sis 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, IV ESSA'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 488 26-2560, 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, TIO: 800.537.7697 or OCRComplaint@I.hs.gov.

Blue Cross Blue Shield of Michigan

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

MESSA ABC & ABC RX

Plan 2 Coins 20%

MESSA

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?	$2,000 Individual/ $4,000 Family	$4,000 Individual/ $8,000 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 policy, the overall family deductible must be met before the plan begins to pay.
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)	$4,000 Individual/ $7,500 Family	$8,000 Individual/ $16,000 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, the overall family out-of-pocket limit must be 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	20%coinsurance	40% coinsurance	None
	Specialist visit	20%coinsurance	40% coinsurance	None
	Preventive care/ screening/ immunization	No Charge; deductible 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.
If you have a test	Diagnostic test (x-ray, blood work)	20%coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20%coinsurance	40% coinsurance	May require preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.messa.org	Generic or prescribed over-the-counter drugs	$10 copay/prescription for retail 34-day supply; $20 copay/prescription for retail and mail order 90-day supply	In-Network copay plus an additional 25% of the approved amount	Preventive drugs covered in full. Mail order drugs are not covered out-of-network.
	Preferred brand-name drugs	$40 copay/prescription for retail 34-day supply; $80 copay/prescription for retail and mail order 90-day supply	In-Network copay plus an additional 25% of the approved amount	
	Non-preferred brand-name drugs	$40 copay/prescription for retail 34-day supply; $80 copay/prescription for retail and mail order 90-day supply	In-Network copay plus an additional 25% of the approved amount	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20%coinsurance	40% coinsurance	None
	Physician/surgeon fees	20%coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20%coinsurance	20%coinsurance	None
	Emergency medical transportation	20%coinsurance	20%coinsurance	Mileage limits apply
	Urgent care	20%coinsurance	40% coinsurance	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)	20%coinsurance	40% coinsurance	Preauthorization is required
	Physician/surgeon fee	20%coinsurance	40% coinsurance	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	20%coinsurance	40% coinsurance	None
	Inpatient services	20%coinsurance	40% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	No Charge; deductible does not apply	40% coinsurance	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%coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20%coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20%coinsurance	20%coinsurance	Physician certification required.
	Rehabilitation services	20%coinsurance	40% coinsurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	20%coinsurance	40%coinsurance	Applied behavior analysis (ABA) treatment for Autism - when rendered by a Licensed Behavior Analyst (LBA) - subject to preauthorization.
	Skilled nursing care	20%coinsurance	20%coinsurance	Physician certification required. Limited to 120 days per member per calendar year
	Durable medical equipment	20%coinsurance	20%coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	20%coinsurance	20%coinsurance	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)	
If your child needs dental or eye care 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, 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 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	**$2,000**
Specialist coinsurance	**20%**
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:

Cost Sharing	
Deductibles	$2,000
Copayments	$10
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,670**

Managing Joe's Type 2 Diabetes
(a year of routine in network care of a well controlled condition)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**20%**
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:

Cost Sharing	
Deductibles	$2,000
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,720**

Mia's Simple Fracture
(in network emergency room visit and follow up care)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**20%**
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:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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.

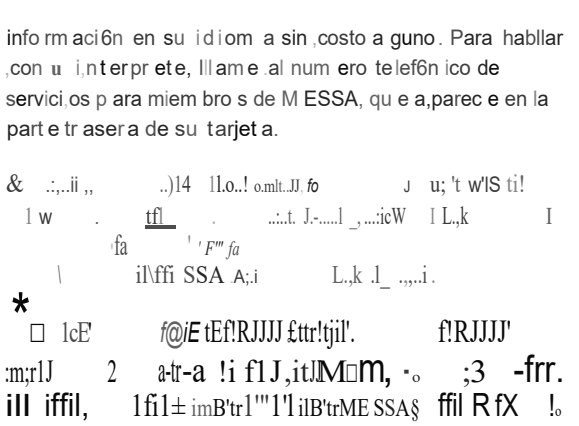
The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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.

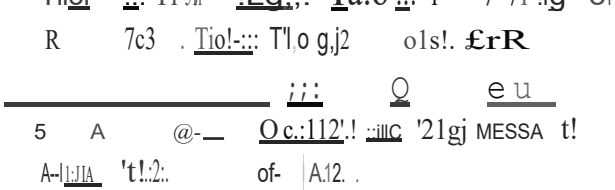
Si usted, o alguien a quien usted estii ayudando, necesita asistencia, tiene derecho a obtener ayuda e

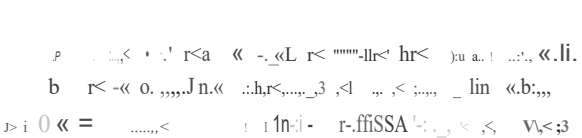
informaci6n en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telef6nico de servicios para miembros de MESSA, que aparece en la parte trasera de su tarjeta.

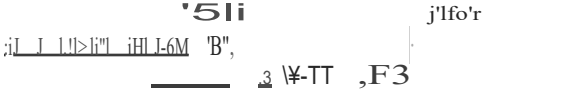


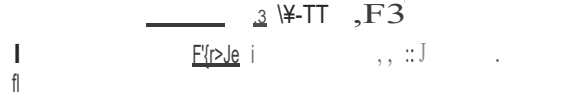
Neu quy vi ho cai, do mat quy vi dang giup do, dinh S'il giup do, quy vi c6 quyen dtrQ'C tr(?i gi up va nh n thong tin b ng ngon ngU" cua quy vi mi n phi. E>e n6i, chuy n vO'i m q,tt hon g d,chvie,n hay gqi den SO d jch vi,i th anh vien MESSA tren m :t sau cua the.

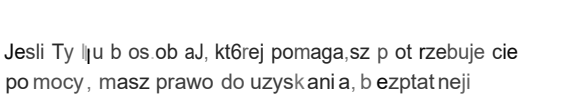
Ne.se ju ose dikush qe po ndih m oni, ka nevoje per a,sistence, keni te drejte te merm i ndihme dhe informacion falas ne gjuhen tuaj. Per te fo lur me nje perl<t:hy es , telefo noni numrin e sherbimit te an etares imit MESSA ne anen e pasm e te kartes · u aji.





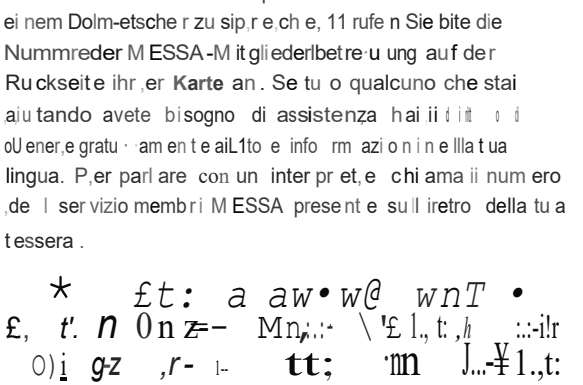


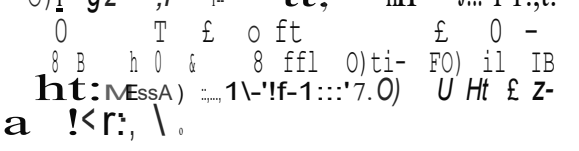




Jesli Ty lub os.ob aJ, kt6rej pomaga,sz p ot rzebuje cie po mocy, masz prawo do uzyskania, b ezptat neji info rm acji i po mo cy we wtasny m ji:z yku. Aby poroz mawia,c z t tu maczem , zad zwo.n pod ru 1m er d ziatu obstugi czto n kow MESSA w sb m m y na odwr ocie Twojej kart y.

falls Sie oder jemand, dem Sie helfen, Unte,rstu tztm g b en otigen, haben Si e d'as Rec ht kostenlose H il fe und 1:nfo rm at ionen in Ihr er Sprac he zu erlhalt en . Um mit ei nem Dolm-etsche r zu sip,r e,ch e, 11 rufe n Sie bite die Nummreder M ESSA-M itgliederlbetre·u ung auf der Ruckseite ihr ,er Karte an . Se tu o qualcuno che stai ,aiutando avete bisogno di assistenza, hai ii d i t o d oUener,e gratu · am en t e aiL1to e info rm azio n i n e llla t ua lingua. P,er parl are con un inter pr et, e chi ama ii num ero ,de l servizio membri M ESSA present e su ll iretro della tu a tessera .





Tenedpo Ha M ES.SA OT,I]leJla 0 6 CJ1ym.t BaH Mi:l KJil '1eftTOB, yKa 3a ,HOMY Ha, o6paTH,OH cropo He Ba weCt 11aPTbl. Ukoliko j e vama illi n ekom kome pomazet e pot ;rebna, p omoc, imat e pravo ,dobiti pomo c l in form acij u na va,sem jez.iku h esp latno. Da biste razgovara li sa prevodiocem, pozovite brnj .za u lsuge i:l ano1'1Ja M ESSA na zadnjoj st,rani vase kart,ice.

Ktm g ikaw, o ang iyong tinutuhm gan, ay nainganga ilanga n ng tulo ng, may karapa,tan kan g

m akakuha ng tu long at imporm asyo n sa iy on g wika nang w alang gastos. Upang m akausap ang isang interpre·t e r, tum aw ag s.a num ero para sa, m.gaserbisyo sa miiYembro ngM ESSA na nasa likuran ng iyong card.

Important disclosure

MESSA and Blue Cross Blue Shield of Michigan, (BCBSM:) comply with federal ,civil right s laws and do not ,discriminate on the ba,sis 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, IV ESSA'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 488 26-2560, 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, TIO: 800.537.7697 or OCRComplaint@I.hs.gov.

Blue Cross Blue Shield of Michigan

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

MESSA Choices

Saver RX w/Mandatory Mail

MESSA

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?	$500 Individual/ $1,000 Family	$1,000 Individual/ $2,000 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)	$1,500 Individual/ $3,000 Family	$3,000 Individual/ $6,000 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	$20 copay/office visit	20% coinsurance	None
	Specialist visit	$20 copay/office visit	20% coinsurance	None
	Preventive care/ screening/ immunization	No Charge; deductible 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.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance	May require preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.messa.org	Generic or prescribed over-the-counter drugs	$10 copay/prescription for retail 34-day supply; $20 copay/prescription for mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	Preventive drugs covered in full. Your prescription drug coverage has a separate out-of-pocket limit of $1,000/$2,000. 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. Mail order drugs are not covered out-of-network.
	Preferred brand-name drugs	$40 copay/prescription for retail 34-day supply; $80 copay/prescription for mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
	Non-preferred brand-name drugs	$40 copay/prescription for retail 34-day supply; $80 copay/prescription for mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% coinsurance	None
	Physician/surgeon fees	No Charge	20% coinsurance	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	Emergency room care	$50 copay/visit	$50 copay/visit	Copay waived if admitted or for an accidental injury.
	Emergency medical transportation	No Charge	No Charge	Mileage limits apply
	Urgent care	$25 copay/visit	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% coinsurance	Preauthorization is required
	Physician/surgeon fee	No Charge	20% coinsurance	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	20% coinsurance	20% coinsurance	None
	Inpatient services	No Charge	20% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	No Charge; deductible does not apply	20% coinsurance	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	No Charge	20% coinsurance	None
	Childbirth/delivery facility services	No Charge	20% coinsurance	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 help recovering or have other special health needs	Home health care	No Charge	No Charge	Physician certification required.
	Rehabilitation services	No Charge	20% coinsurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	No Charge	20% coinsurance	Applied behavior analysis (ABA) treatment for Autism - when rendered by a Licensed Behavior Analyst (LBA) - subject to preauthorization.
	Skilled nursing care	No Charge	No Charge	Physician certification required. Limited to 120 days per member per calendar year
	Durable medical equipment	No Charge	No Charge	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge	No Charge	Physician certification required. Unlimited visits.
If your child needs dental or eye care 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, 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 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	**$500**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$570**

Managing Joe's Type 2 Diabetes
(a year of routine in network care of a well controlled condition)

The plan's overall deductible	**$500**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

Mia's Simple Fracture
(in network emergency room visit and follow up care)

The plan's overall deductible	**$500**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

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.

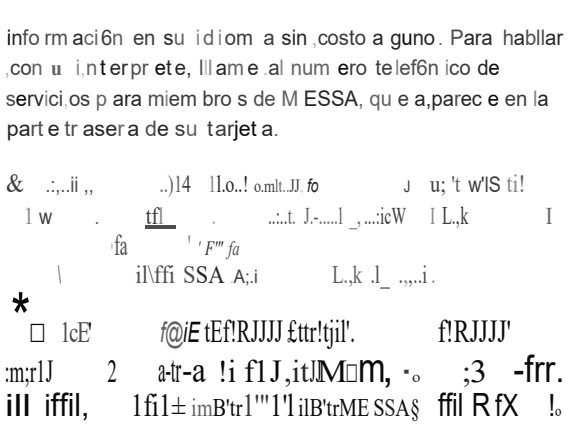
The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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.

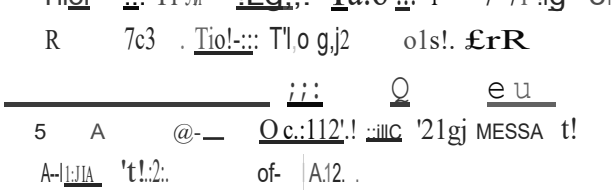
Si usted, o alguien a quien usted estii ayudando, necesita asistencia, tiene derecho a obtener ayuda e

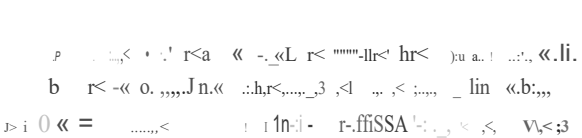
informaci6n en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telef6nico de servicios para miembros de MESSA, que aparece en la parte trasera de su tarjeta.

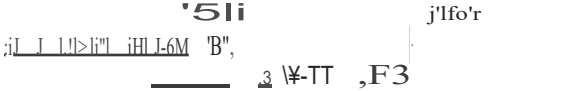


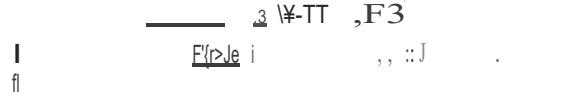
Neu quy vi ho cai, do mat quy vi dang giup do, dinh S'il giup do, quy vi c6 quyen dtrQ'C tr(?i gi up va nh n thong tin b ng ngon ngU" cua quy vi mi n phi. E>e n6i, chuy n vO'i m q,tt hon g d,chvie,n hay gqi den SO d jch vi,i th anh vien MESSA tren m :t sau cua the.

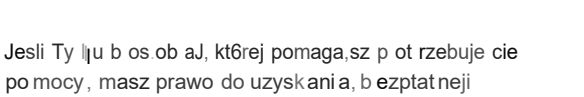
Ne.se ju ose dikush qe po ndih m oni, ka nevoje per a,sistence, keni te drejte te merm i ndihme dhe informacion falas ne gjuhen tuaj. Per te fo lur me nje perl<t:hy es , telefo noni numrin e sherbimit te an etares imit MESSA ne anen e pasm e te kartes · u aji.





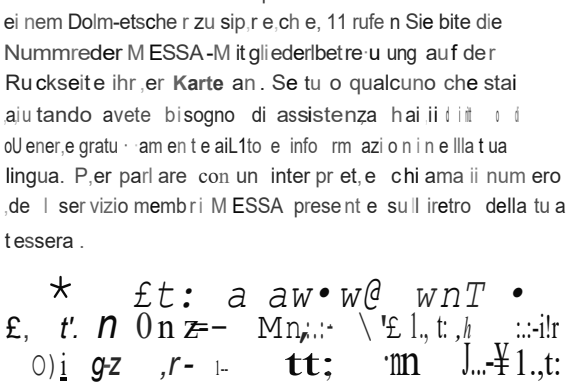


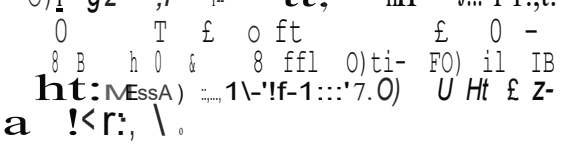




Jesli Ty lub os.ob aJ, kt6rej pomaga,sz p ot rzebuje cie po mocy, masz prawo do uzyskania, b ezptat neji info rm acji i po mo cy we wtasny m ji:z yku. Aby poroz mawia,c z t tu maczem , zad zwo.n pod ru 1m er d ziatu obstugi czto n kow MESSA w sb m m y na odwr ocie Twojej kart y.

falls Sie oder jemand, dem Sie helfen, Unte,rstu tztm g b en otigen, haben Si e d'as Rec ht kostenlose H il fe und 1:nfo rm at ionen in Ihr er Sprac he zu erlhalt en . Um mit ei nem Dolm-etsche r zu sip,r e,ch e, 11 rufe n Sie bite die Nummreder M ESSA-M itgliederlbetre·u ung auf der Ruckseite ihr ,er Karte an . Se tu o qualcuno che stai ,aiutando avete bisogno di assistenza, hai ii d i t o d oUener,e gratu · am en t e aiL1to e info rm azio n i n e llla t ua lingua. P,er parl are con un inter pr et, e chi ama ii num ero ,de l servizio membri M ESSA present e su ll iretro della tu a tessera .





Tenedpo Ha M ES.SA OT,I]leJla 0 6 CJ1ym.t BaH Mi:l KJil '1eftTOB, yKa 3a ,HOMY Ha, o6paTH,OH cropo He Ba weCt 11aPTbl. Ukoliko j e vama illi n ekom kome pomazet e pot ;rebna, p omoc, imat e pravo ,dobiti pomo c l in form acij u na va,sem jez.iku h esp latno. Da biste razgovara li sa prevodiocem, pozovite brnj .za u lsuge i:l ano1'1Ja M ESSA na zadnjoj st,rani vase kart,ice.

Ktm g ikaw, o ang iyong tinutuhm gan, ay nainganga ilanga n ng tulo ng, may karapa,tan kan g

m akakuha ng tu long at imporm asyo n sa iy on g wika nang w alang gastos. Upang m akausap ang isang interpre·t e r, tum aw ag s.a num ero para sa, m.gaserbisyo sa miiYembro ngM ESSA na nasa likuran ng iyong card.

Important disclosure

MESSA and Blue Cross Blue Shield of Michigan, (BCBSM:) comply with federal ,civil right s laws and do not ,discriminate on the ba,sis 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, IV ESSA'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 488 26-2560, 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, TIO: 800.537.7697 or OCRComplaint@I.hs.gov.

Blue Cross Blue Shield of Michigan

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

MESSA Choices

Coins 20% Saver RX w/Mandatory Mail

MESSA

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?	$1,000 Individual/ $2,000 Family	$2,000 Individual/ $4,000 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)	$3,000 Individual/ $6,000 Family	$6,000 Individual/ $12,000 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	$20 copay/office visit	40% coinsurance	None
	Specialist visit	$20 copay/office visit	40% coinsurance	None
	Preventive care/ screening/ immunization	No Charge; deductible 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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	May require preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.messa.org	Generic or prescribed over-the-counter drugs	$10 copay/prescription for retail 34-day supply; $20 copay/prescription for mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	Preventive drugs covered in full. Your prescription drug coverage has a separate out-of-pocket limit of $1,000/$2,000. 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. Mail order drugs are not covered out-of-network.
	Preferred brand-name drugs	$40 copay/prescription for retail 34-day supply; $80 copay/prescription for mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
	Non-preferred brand-name drugs	$40 copay/prescription for retail 34-day supply; $80 copay/prescription for mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	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	Emergency room care	$50 copay/visit	$50 copay/visit	Copay waived if admitted or for an accidental injury.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Mileage limits apply
	Urgent care	$25 copay/visit	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required
	Physician/surgeon fee	20% coinsurance	40% coinsurance	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	No Charge; deductible does not apply	40% coinsurance	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% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	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 help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Physician certification required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	20% coinsurance	40% coinsurance	Applied behavior analysis (ABA) treatment for Autism - when rendered by a Licensed Behavior Analyst (LBA) - subject to preauthorization.
	Skilled nursing care	20% coinsurance	20% coinsurance	Physician certification required. Limited to 120 days per member per calendar year
	Durable medical equipment	20% coinsurance	20% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	20% coinsurance	20% coinsurance	Physician certification required. Unlimited visits.
If your child needs dental or eye care 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, 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 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	**$1,000**
Specialist copayment	**$20**
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:

Cost Sharing	
Deductibles	$1,000
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,870**

Managing Joe's Type 2 Diabetes
(a year of routine in network care of a well controlled condition)

The plan's overall deductible	**$1,000**
Specialist copayment	**$20**
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:

Cost Sharing	
Deductibles	$1,000
Copayments	$700
Coinsurance	$90
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,810**

Mia's Simple Fracture
(in network emergency room visit and follow up care)

The plan's overall deductible	**$1,000**
Specialist copayment	**$20**
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:

Cost Sharing	
Deductibles	$1,000
Copayments	$50
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,250**

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 estii 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 está en la parte trasera de su tarjeta.

Nếu quý vị hoặc người quý vị đang giúp đỡ, cần sự giúp đỡ, quý vị có quyền được cung cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Gọi cho Trung Tâm Dịch Vụ Hội Viên của MESSA theo số 800.336.0013 hoặc TTY 888.445.5614.

Nếse juose dikush qe po ndihmoni, ka nevoje për asistence, keni të drejte te merrni ndihme dhe informacion falas në gjuhen tuaj. Për të folur me një përkthyes, telefononi numrin e sherbimit të anetarësimit MESSA në anën e pasme të kartës suaj.

Tilol :::: Ti"5Tl !Lg:;:: 1a:o ::: T 7 7i !ig o1 R 7c3 . Tio!-:::: T'l o g,j2 o1s!. £rR

5 A @-__ Oc.:112'.! :illC '21gj MESSA t! A--l1:JIA 't!.:2:. of- A.12. .

Tenedpo Ha M ES.SA OT,I]leJla 0 6 CJ1ym.t BaH Mi:l KJil '1eftTOB, yKa 3a ,HOMY Ha, o6paTH,OH cropo He Ba weCt 11aPTbl. Ukoliko je vama ili n ekom kome pomazet e pot ;rebna, pomoc, imat e pravo ,dobiti pomo c I in form acij u na va,sem jez.iku h esplatno. Da biste razgovara li sa prevodiocem, pozovite brnj .za u lsuge i:l ano1Ja M ESSA na zadnjoj st,rani vase kart,ice.

Ktm g ikaw, o ang iyong tinutuhm gan, ay nainganga ilanga n ng tulo ng, may karapa,tan kan g makakuha ng tu long at imporm asyo n sa iy ong wika nang w alang gastos. Upang m akausap ang isang interpre·t e r, tum awag s.a num ero para sa, m.gaserbisyo sa miiYembro ngM ESSA na nasa likuran ng iyong card.

Important disclosure

MESSA and Blue Cross Blue Shield of Michigan, (BCBSM:) comply with federal ,civil right s laws and do not ,discriminate on the ba,sis 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, IV ESSA'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, TIO: 800.537.7697 or OCRComplaint@I.hs.gov.