

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

MESSA ABC & 3-Tier Rx



Plan 1 Coins 10% w/ Mandatory Mail

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: Beginning on or after 01/01/2020

Coverage for: Individual/Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 800-336-0013. For general definitions of common terms, such as allowed amount, <a href="mailto:bolder: bolder: bold

Important Quantiana	Answers		Why This Mottors	
Important Questions	In-Network	Out-of-Network	Why This Matters:	
What is the overall <u>deductible</u> ?	\$1,400 Individual/ \$2,800 Family	\$2,800 Individual/ \$5,600 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.	
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .		This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .	
Are there other <u>deductibles</u> for specific services?	No.		You don't have to meet <u>deductibles</u> for specific services.	
What is the <u>out-of-pocket</u> limit for this <u>plan</u> ? (May include a <u>coinsurance</u> maximum)	\$4,400 Individual/ \$6,900 Family	\$8,800 Individual/ \$17,600 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.	
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, 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 <u>out-of-pocket limit</u> .	
Will you pay less if you use a <u>network</u> <u>provider</u> ?	Yes. For a list of <u>network providers</u> see <u>www.messa.org</u> or call MESSA at 800-336-0013.		This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pay (<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.

		What Yo	ou Will Pay	Limitations Expontions 9 Other Important	
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	30% coinsurance	None	
If you visit a health care	Specialist visit	10% coinsurance	30% coinsurance	None	
provider's 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 <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>pl</u> will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None	
If you have a test	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	May require <u>preauthorization</u> .	
	Generic or prescribed over-the-counter drugs (Tier 1)	\$10 <u>copay</u> /prescription for retail 34-day supply, \$25 <u>copay</u> /prescription for 90-day mail order supply	\$10 copay/prescription for 34- day supply plus an additional 25% of BCBSM approved amount for the drug		
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at	Preferred brand-name drugs (Tier 2)	20% coinsurance with \$40 min and \$80 max/prescription for retail 34-day supply, 20% coinsurance with \$100 min and \$200 max/prescription for 90-day mail order supply	20% coinsurance with \$40 min and \$80 max/prescription for 34-day supply plus an additional 25% of BCBSM approved amount for the drug	Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. A 90-day supply of prescription drugs is not payable at a retail pharmacy. A 90-day supply is only payable at a participating mail order pharmacy. Mail order drugs are not covered out-of-network.	
www.messa.org	Non-Preferred brand- name drugs (Tier 3)	20% coinsurance with \$60 min and \$100 max/prescription for retail 34-day supply, 20% coinsurance with \$150 min and \$250 max/prescription for 90-day mail order supply	20% coinsurance with \$60 min and \$100 max/prescription for 34-day supply plus an additional 25% of BCBSM approved amount for the drug		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% coinsurance	None	
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None	
	Emergency room care	10% coinsurance	10% coinsurance	None	

What You Will Pay		Limitations, Exceptions, & Other Important		
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
If you need immediate medical attention	Emergency medical transportation	10% coinsurance	10% coinsurance	Mileage limits apply.
medical attention	<u>Urgent care</u>	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization is required.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	None
If you need mental health,	Outpatient services	10% coinsurance	30% coinsurance	None
behavioral health, or substance use disorder services	Inpatient services	10% coinsurance	30% coinsurance	<u>Preauthorization</u> is required.
lf von our museum	Office visits	No charge; <u>deductible</u> does not apply	30% coinsurance	Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. Cost sharing does not apply to certain maternity services considered to be preventive.
If you are pregnant	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	None
	Home health care	10% coinsurance	10% coinsurance	Preauthorization is required.
	Rehabilitation services	10% coinsurance	30% coinsurance	Physical, Occupational, Speech therapy is limited to a combined maximum of 60 visits per member, per calendar year.
If you need help recovering or have other special health needs	Habilitation services	10% coinsurance	30% coinsurance	Applied behavioral analysis (ABA) treatment for Autism – when rendered by an approved board-certified analyst – is covered through age 18, subject to preauthorization.
	Skilled nursing care	10% coinsurance	10% coinsurance	Preauthorization is required. Limited to a maximum of 120 days per member, per calendar year.
	Durable medical equipment	10% coinsurance	10% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.

		What Yo	ou Will Pay	Limitations, Exceptions, & Other Important
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
	Hospice services	10% coinsurance	10% coinsurance	Preauthorization is required. Unlimited visits.
If your child needs dental or	Children's eye exam	Not Covered	Not Covered	None
eye care		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 - Routine foot care

Dental care (Adult)	 Routine eye care (Adult) 	 Weight Loss programs
 Dental care (Adult) Other Covered Services (Limitations may apple - Acupuncture Bariatric surgery Chiropractic care 	 Routine eye care (Adult) Poly to these services. This isn't a complete list. Please se Coverage provided outside the United States. See www.messa.org Hearing Aids If you are also covered by an account-type plan 	ÿ , ÿ
	• 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 <u>deductible</u> , <u>copayments</u> , or <u>coinsurance</u> , or benefits not otherwise covered.	

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 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact MESSA by calling 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.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

Language Access Services: See Addendum

If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>. (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.)

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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,400
■ Specialist copayment	10%
■ Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:

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

Total Example Cost

In this example, Peg would pay:		
Cost Sharing		
Deductibles	\$1,400	
Copayments	\$40	
Coinsurance	\$890	
What isn't covered		
Limits or exclusions	\$0	
The total Peg would pay is	\$2,330	

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,400
Specialist copayment	10%
■ Hospital (facility) coinsurance	10%
Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
Diagnostic tests (blood work)

Prescription drugs

\$12,700

Total Example Cost

Durable medical equipment (glucose meter)

Total Example Cost	400, 400
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$1,400
Copayments	\$310
Coinsurance	\$830
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,540

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,400
■ Specialist copayment	10%
■ Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic tests (*x-ray*)

Total Example Cost

¢7 400

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

	7 - ,
n this example, Mia would pay:	
Cost Sharing	
Deductibles	\$1,400
Copayments	\$0
Coinsurance	\$50
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,450

\$1.900

Language services

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

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

إذا كنت أنت أو شخص آخر تساعده بحاجة إلى المساندة، فمن حقّك الحصول على المساعدة والمعلومات بلغتك بدون أيّ كلفة التحدّث إلى مترجم، انصل بالرقم المخصّص مترجم، انصل بالرقم المخصّص الموجود على ظهر بطاقتك MESSA لخدمات أعضاء

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

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

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

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

যদি আপনার বা আপদন সাহায্য কররন eমন কাররা সহায়তার pরয়াজন হয়, তাহরে ককারনা খরচ ছাড়া। আপনার ভাষায় সহায়তা o তথ্য পাত্যার aদিকার ররয়রছ। ককারনা কোভাষীর সার্থ কথ্া বেরত, আপনার কার্ডের কপছরন fpt MESSA সিস্য পদর্রষ্বার নাল্রর কে ক ন।

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 <a href="https://ocen.pubme.com/ocen