Blue Cross Blue Shield of Michigan

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

MESSA

Good health. Good business. Great schools.

MESSA ABC Plan 1

Summary of Benefits and Coverage: What this Plan Covers & What it Costs*

Coverage Period: Beginning on or after 01/01/2017

Coverage for: Individual / Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.messa.org or by calling MESSA at 800-336-0013.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$1,300 Individual/ $2,600 Family	$2,600 Individual / $5,200 Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	No.	You don't have to meet deductibles for specific services, but see the Common Medical Event chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	$2,300 Individual/ $4,600 Family	$4,600 Individual / $9,200 Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.		The Common Medical Events chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.messa.org or call MESSA at 800-336-0013.		If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the Common Medical Events Chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.		You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.		Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

MESSA ABC, Group Number 71452, 71453; 161 162

Questions: Call MESSA at 800-336-0013 or visit us at www.messa.org. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/healthreform or call MESSA at 800-336-0013 to request a copy.

*This plan or selected benefits within this plan are underwritten by 4 Ever Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association and administered by Blue Cross Blue Shield of Michigan.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge after deductible	20% co-insurance after deductible	---none---
	Specialist visit	No Charge after deductible	20% co-insurance after deductible	---none---
	Other practitioner office visit	No Charge after deductible for chiropractor	20% co-insurance after deductible	Limited to a maximum of 38 visits per member per calendar year for spinal manipulations.
	Preventive care/screening/ immunization	No Charge	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	No Charge after deductible	20% co-insurance after deductible	---none---
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	20% co-insurance after deductible	Imaging subject to preauthorization.
If you need drugs to treat your illness or condition For more information about prescription drug coverage, go to www.messa.org.	Generic or prescribed over-the-counter drugs	$10 co-pay after deductible for retail 34-day supply; $20 co-pay after deductible for retail and mail order 90 day supply.	$10 Co-pay plus an additional 25% of BCBSM approved amount for the drug.	For information on women's contraceptive coverage, go to www.messa.org. Mail order drugs are not covered out-of-network.
	Preferred brand-name drugs	$40 co-pay after deductible for retail 34-day supply; $80 co-pay after deductible for retail and mail order 90 day supply.	$40 Co-pay plus an additional 25% of BCBSM approved amount for the drug.	
	Non-Preferred brand-name drugs	$40 co-pay after deductible for retail 34-day supply; $80 co-pay after deductible for retail and mail order 90 day supply.	$40 Co-pay plus an additional 25% of BCBSM approved amount for the drug.	

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible	20% co-insurance after deductible	---none---
	Physician/surgeon fees	No Charge after deductible	20% co-insurance after deductible	---none---
If you need immediate medical attention	Emergency room services	No Charge after deductible	No Charge after deductible	Co-pay waived if admitted.
	Emergency medical transportation	No Charge after deductible	No Charge after deductible	---none---
	Urgent care	No Charge after deductible	20% co-insurance after deductible	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	20% co-insurance after deductible	---none---
	Physician/surgeon fee	No Charge after deductible	20% co-insurance after deductible	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge after deductible	20% co-insurance after deductible	---none---
	Mental/Behavioral health inpatient services	No Charge after deductible	20% co-insurance after deductible	---none---
	Substance use disorder outpatient services	No Charge after deductible	20% co-insurance after deductible	---none---
	Substance use disorder inpatient services	No Charge after deductible	20% co-insurance after deductible	---none---
If you are pregnant	Prenatal and postnatal care	Prenatal: No Charge Postnatal: No Charge after deductible	20% co-insurance after deductible	---none---
	Delivery and all inpatient services	No Charge after deductible	20% co-insurance after deductible	---none---

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge after deductible	No Charge after deductible	---none---
	Rehabilitation services	No Charge after deductible	20% co-insurance after deductible	Physical, Occupational, Speech therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	No Charge after deductible	20% co-insurance after deductible	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	No Charge after deductible	No Charge after deductible	Limited to a maximum of 120 days per member per calendar year.
	Durable medical equipment	No Charge after deductible	No Charge after deductible	---none---
	Hospice service	No Charge after deductible	No Charge after deductible	---none---
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	---none---
	Glasses	Not Covered	Not Covered	---none---
	Dental check-up	Not Covered	Not Covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See www.messa.org
- Hearing aids
- 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, co-payments, or co-insurance, or benefits not otherwise covered.
- Infertility treatment
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan by calling MESSA at 800-336-0013. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact MESSA Legal and Compliance by calling 1-800-742-2328. Or, you can contact Michigan Office of Financial and Insurance Regulation at **www.michigan.gov/ofir** or 1-877-999-6442. For group health coverage subject to ERISA, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides. (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**

4 Ever Life Insurance Company is the underwriter of this plan or selected benefits within this plan. Blue Cross Blue Shield of Michigan does not underwrite or assume any financial risk with respect to the claims liability associated with any 4 Ever Life underwritten health care products, as BCBSM is an administrator for 4 Ever Life products. 4 Ever Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association, is a wholly owned subsidiary of BCS Financial Corporation.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much insurance protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Please note: Coverage Examples are calculated based on individual coverage and calculations may not include a coinsurance maximum..

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,070
- **You pay** $1,470

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,300
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$150
Total	**$1,470**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,660
- **You pay** $1,740

Sample care costs:

Prescriptions	$2,900
Medical Equipment & Supplies	$1,300
Office Visits & Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,300
Co-pays	$360
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,740**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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. إلى مترجم، اتّصل بالرقم المخصّص لخدمات أعضاء MESSA الموجود على ظهر بطاقتك.

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

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

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

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

[illegible] MESSA [illegible]

যদি আপনার বা আপদন সাহাযয কররন এমন কাররা সহায়তার প্ররয়াজন হয়, তাহরে ককারনা খরচ ছাড়াই আপনার ভাষায় সহায়তা ও তথ্য পাওয়ার অদিকার ররয়রছ। ককারনা কিাভাষীর সারথ্ কথ্া বেরত, আপনার কারডের কপছরন প্রিত্ত MESSA সিসয পদররষবার নম্বরর কে করুন।

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

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

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

Если Вам или лицу, которому Вы помогаете, нужна помощь, то Вы имеете право на бесплатное получение помощи и информации на Вашем языке. Для разговора с переводчиком позвоните по номеру телефона MESSA отдела обслуживания клиентов, указанному на обратной стороне Вашей карты.

Ukoliko je vama ili nekom kome pomažete potrebna pomoć, imate pravo dobiti pomoć I informaciju na vašem jeziku besplatno. Da biste razgovarali sa prevodiocem, pozovite broj za ulsuge članova MESSA na zadnjoj strani vaše kartice.

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

Important disclosure

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

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

You can also file a civil rights complaint with the Office for Civil Rights on the web at OCRComplaint@hhs.gov, or by mail, phone or email: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, 800.368.1019, TTD: 800.537.7697, or OCRComplaint@hhs.gov.