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

Coverage Period: Beginning on or after 01/01/2023

MESSA



MESSA ABC & ABC RX

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association Plan 1 Coins 20%

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 <u>www.messa.org</u> or call MESSA at 1-800-336-0013. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <u>https://www.healthcare.gov/sbc-glossary</u> or call MESSA at 1-800-336-0013 to request a copy.

Important Quastiana	Answers		Why this Matters	
Important Questions	In-Network	Out-of-Network	Why this Matters:	
What is the overall <u>deductible</u> ?	\$1,500 Individual/ \$3,000 Family	\$3,000 Individual/ \$6,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the 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> before you meet you		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 (<u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u>).	
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 limit</u> for this <u>plan</u> ? (May include a <u>coinsurance</u> maximum)	\$3,500 Individual/ \$7,000 Family	\$7,000 Individual/ \$14,000 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-</u> pocket limit?	Premiums, <u>balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this <u>plan</u> 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 provider</u> ?	Yes. For a list of <u>network providers</u> see (<u>http://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 <u>plan's</u> <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.	
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.		You can see the <u>specialist</u> you choose without a <u>referra</u> l.	



All **<u>copayment</u>** and <u>**coinsurance**</u> costs shown in this chart are after your <u>**deductible**</u> has been met, if a <u>**deductible**</u> applies.

	What You Will Pay		ou Will Pay	Limitations Excontions & 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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None	
If you visit a health care	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None	
provider's office or clinic	<u>Preventive care</u> / <u>screening</u> / 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>plan</u> will pay for.	
	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None	
If you have a test	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	May require <u>preauthorization</u>	
If you need drugs to treat	Generic or prescribed over-the-counter drugs	\$10 <u>copay</u> /prescription for retail 34-day supply; \$20 <u>copay</u> /prescription for retail and mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount		
your illness or condition More information about prescription drug coverage is available at	Preferred brand-name drugs	\$40 <u>copav</u> /prescription for retail 34-day supply; \$80 <u>copay</u> /prescription for retail and mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	<u>Preventive</u> drugs covered in full. Mail order drugs are not covered out-of-network.	
www.messa.org	Non-preferred brand- name drugs	\$40 <u>copay</u> /prescription for retail 34-day supply; \$80 <u>copay</u> /prescription for retail and mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None	
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None	
	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None	
If you need immediate medical attention	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Mileage limits apply	
	Urgent care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None	

	What You Will Pa		ou Will Pay	Limitationa Evantiona 8 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
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization is required
	Physician/surgeon fee	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need behavioral	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
health services (mental health and substance use disorder)	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization is required.
If you are pregnant	Office visits	No Charge; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services <u>cost share</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Home health care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Physician certification required.
	Rehabilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
If you need help recovering or have other special health		20% <u>coinsurance</u>	40% <u>coinsurance</u>	Applied behavior analysis (ABA) treatment for Autism - when rendered by a Licensed Behavior Analyst (LBA) - subject to <u>preauthorization</u> .
needs	Skilled nursing care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Physician certification required. Limited to 120 days per member per calendar year
	<u>Durable medica</u> l <u>equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Physician certification required. Unlimited visits.

		What Yo	ou Will Pay	Limitations, Exceptions, & Other Important
Common Medical Event	mon Medical Event Services You May Need		Out-of-Network Provider (You will pay the most)	Information
If your child needs dental or	Children's eye exam	Not covered	Not covered	None
eye care For more information on	Children's glasses	Not covered	Not covered	None
pediatric vision or dental, contact your plan administrator	Children's dental check- up	Not covered	Not covered	None

Excluded Services & Other Covered Services Vour Plan Concerdly Dece NOT	vices: Cover (Check your policy or plan document for more informa	ation and a list of any other evaluated convises)
 Cosmetic Surgery Dental care (Adult) 	Long term care Routine eye care (Adult)	 Routine foot care Weight loss programs
Other Covered Services (Limitations ma	y apply to these services. This isn't a complete list. Please se	e <u>your plan</u> document.)
Acupuncture treatment	 Coverage provided outside the United States. See (http://www.messa.org) 	Non-emergency care when traveling outside the U.S
Bariatric surgery	 Private-duty nursing Hearing aids 	Private-duty nursing
Chiropractic care	Infertility treatment	

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 <u>www.dol.gov/ebsa/healthreform</u>, 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 <u>www.cciio.cms.gov</u> or by calling 1-800-324-6172. Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> 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 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/difs or difs-HICAP@michigan.gov/difs or difs-HICAP@michigan.gov/difs or difs-HICAP@michigan.gov/difs or difs-HICAP@michigan.gov/difs

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 <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 <u>plan</u> may be affected if your <u>plan</u> does not cover certain EHB categories, such as <u>prescription drugs</u>, or if your <u>plan</u> provides coverage of specific EHB categories, for example <u>prescription drugs</u>, 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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia (in-networ	
The <u>plan's</u> overall <u>deductible</u>	\$1,500	The <u>plan's</u> overall <u>deductible</u>	\$1,500	The <u>plan's</u> o	
<u>Specialist</u> <u>coinsurance</u>	20%	<u>Specialist</u> <u>coinsurance</u>	20%	<u>Specialist</u> co	
Hospital (facility) <u>coinsurance</u>	20%	Hospital (facility) <u>coinsurance</u>	20%	Hospital (fac	
Other <u>coinsurance</u>	20%	Other <u>coinsurance</u>	20%	Other <u>coinsu</u>	
This EXAMPLE event includes services like:		This EXAMPLE event includes servic		This EXAMPLE	
<u>Specialist</u> office visits (<i>prenatal care</i>)		<u>Primary care physician</u> office visits (incl		Emergency room	
Childbirth/Delivery Professional Services		disease education)		supplies)	
Childbirth/Delivery Facility Services		<u>Diagnostic tests</u> (blood work)		Diagnostic tests	
<u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>)		Prescription drugs		Durable medical	

Specialist visit (anesthesia)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
Deductibles	\$1,500
<u>Copayments</u>	\$10
Coinsurance	\$1,700
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,270

Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u>	
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
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\$1,500
\$500
\$200
\$20
\$2,220

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

The <u>plan's</u> overall <u>deductible</u>	\$1,500
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
Other coinsurance	20%

E event includes services like:

om care (including medical ts (x-ray) Durable medical equipment (crutches) Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$10
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,810

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.

Langua,ge s er v i ces

If you, or some offer you're helping, ffeeds assist ance, you haive the r ight to get help and if 1 formation in your language at no cost. To **talk** Ito am in Ite, p:r ete r, call MESSA'.s M ember Service Center alt S0 0.336.001 3 or TTY 888.445.5614.

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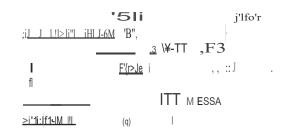
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m akakuha ng tu long at imporm asyon sa iyon g wika nan g w alang gastos. Upang m akausap ang isa ng interpreter, tum aw ag s.a num ero para sa, m.gaserbisyo sa miiYembro ng M ESSA na nasa likuran ng iyong card.

Important disclosure

MESSA and Blue Cross Blife Shie d of M ichigan, (BCBSM:) comp ly with federal ,civill right s laws and do not ,d iscriminate on the ba, sis of race, color, national! o rigin , age disability, or sex. MESSA and BCBSM profilide free au xilli a.y aids and serv ices to peo1Pie w ith d is abilities to comm uni,cate effectijvel y with us, in cluding qualified sign languag ,e in te,rpreters. If you need assist anc,e call M ESSA's M em be ,r Service Center at 8 00.336 .001 3 or TTY 888.4 45.5 614 .

If you need help filing a grievance, IV ESSA's genera I counsel is available to help you. If you belie ve that MESSA or BCBSM fai-ed to provLd estervices or ,d iscrim in at ed in another way on the basis of race, color., na tional origin, ag,e disahi lity, or sex, you can file a grievance in person, or by ma,il phon,e fax or em ail: General Counse II, MESSA P.O. Box. 2560, East Lansing, MI 488 26-2560, 800.29 2.49 J.0, TTY: 888. 445.5613, fax: 517.20 3.29 0.9 or CivilRight s-

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You can also f il e a civil r ight s complaint wit h the Offic e

for Civil Righ ts on t he w eb at OCRComp lain t@hh s.gov.

or by maii I, phon e or email: U.S.. Department of Healt h &. H'uman Serv ices, 200 In dependen ce Av,e S.W.,

Washin gton D.C. 20 201, 800.368.1019, TIO: 800.537.769,7 or <u>OCRComplaint@l.hs.gov</u>.