

MESSA Choices

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

MESSA

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

Saver RX

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 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.

Immertant Occasions	Answers			
Important Questions	In-Network	Out-of-Network	Why this Matters:	
What is the overall <u>deductible</u> ?	\$500 Individual/ \$1,000 Family	\$1,000 Individual/ \$2,000 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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .	
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> before you meet you	services are covered r <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 limit</u> for this <u>plan</u> ? (May include a <u>coinsurance</u> maximum)	\$1,500 Individual/ \$3,000 Family	\$3,000 Individual/ \$6,000 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> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.	
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-bandermacy penalty and 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 network provider?	Yes. For a list of network (http://www.messa.or 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 network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.	
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.		You can see the specialist you choose without a referral.	



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

		What You Will Pay		Limitations Evacutions 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	\$20 copay/office visit	20% coinsurance	None
If you visit a health care	Specialist visit	\$20 copay/office visit	20% 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 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
If you have a test	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance	May require preauthorization
If you need drugs to treat	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; deductible does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	
your illness or condition More information about prescription drug coverage is available at www.messa.org	Preferred brand-name drugs	\$40 copay/prescription for retail 34-day supply; \$80 copay/prescription for retail and mail order 90-day supply; deductible does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	Preventive drugs covered in full. Your prescription drug coverage has a separate out-of-pocket limit of \$1,000/\$2,000. Mail order drugs are not covered out-of-network.
	Non-preferred brand- name drugs	\$40 copay/prescription for retail 34-day supply; \$80 copay/prescription for retail and mail order 90-day supply; deductible does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> 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

		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	
	Emergency room care	\$50 <u>copay</u> /visit	\$50 <u>copay</u> /visit	Copay waived if admitted or for an accidental injury.	
If you need immediate medical attention	Emergency medical transportation	No Charge	No Charge	Mileage limits apply	
	<u>Urgent care</u>	\$25 <u>copay</u> /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	Outpatient services	20% coinsurance	20% coinsurance	None	
health services (mental health and substance use disorder)	Inpatient services	No Charge	20% coinsurance	Preauthorization is required.	
If you are pregnant	Office visits	No Charge; <u>deductible</u> 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	

		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
	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.
If you need help recovering or have other special health		No Charge	20% coinsurance	Applied behavior analysis (ABA) treatment for Autism - when rendered by a Licensed Behavior Analyst (LBA) - subject to <u>preauthorization</u> .
needs	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	Children's eye exam	Not covered	Not covered	None
eye care For more information on pediatric vision or dental, contact your plan administrator	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

Long term care

Routine foot care

Dental care (Adult)

• Routine eye care (Adult)

Weight loss programs

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

Acupuncture treatment

- Coverage provided outside the United States.
 See (http://www.messa.org)
- Non-emergency care when traveling outside the U.S

- Bariatric surgery
- Chiropractic care

- Hearing aids
 - Infertility treatment

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 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 <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

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 <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 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:

<u>Cost Sharing</u>			
<u>Deductibles</u>	\$500		
<u>Copayments</u>	\$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:

<u>Primary care physician</u> 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:

<u>Cost Sharing</u>		
<u>Deductibles</u>	\$500	
<u>Copayments</u>	\$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)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$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 <u>plan</u> 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 <u>out-of-pocket expenses</u> – like the deductible, copayments, or coinsurance, or benefits not otherwise covered.

Langua,ge ser vices

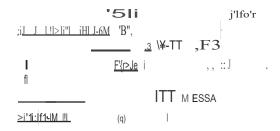
If you, or some offe you're helping, ffeeds assist ance, you haive the right to get help and in Information in your language at no cost. To talk Ito am in Ite, p.r ete r, call MESSA's Member Service Center alt S0 0.336.001 3 or TTY 888.445.5614.

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makakuha ng tu long at imporm asyon sa iyong wika nang walang gastos. Upang makausap ang isang interpreter, tum awag s.a num ero para sa, m.gaserbisyo sa miiYembro ng MESSA na nasa likuran ng iyong card.

Important disclosure

MESSA and Blue Cross Blife Shied of Michigan, (BCBSM:) compily with federal, civill right slaws and do not a discriminate on the ballists of race, color, national! or right age disability, or sex. MESSA and BCBSM profiled free auxillially aids and services to peo1Piewith disabilities to communicate effectively with us, including qualified sign languagie in terror et ers. If you need assist ance call MESSA's Member reservice Center at 8 00.336.0013 or TTY 888.4 45.5 614.

Ilf 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 pro vLd eservices or ,d iscrim in ated in another way on the basis of race, color., national origin, ag,e disahility, or sex, you can file a grievan,ce in person, or by ma,il phon,e fax or email:

General Counse II, MES\$A P.O. B ox. 2560, Ea st Lansing, MI 488 26-2560, 800.29 2.49 J.O, TTY: 888. 445.5613, fa x: 517.20 3.29 0 9 or CivilRi a ht s-

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You can also file a civil right's complaint with the Office for Civil Rights on the web at OCRComplaint@hhs.gov. or by maiil, phone or email: U.S.. Department of Health &. H'uman Services, 200 In dependence Av, e. S. W.,

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