Blue Cross Blue Shield of Michigan

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

MESSA Balance+ & Balance+ RX

PPO

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?	$1,600 Individual/ $3,200 Family	$3,200 Individual/ $6,400 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)	$4,000 Individual/ $8,000 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, 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	$25 copay/office visit	40% coinsurance	Members 18 years and older have access to Virtual Primary Care visits by a BCBSM selected vendor.
	Specialist visit	$50 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

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/druglists	Generic or prescribed over-the-counter drugs	$10 copay/prescription for retail 34-day supply; $30 copay/prescription for retail or mail order 90-day supply	In-Network copay plus an additional 25% of the approved amount	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.
	Preferred brand-name drugs	$40 copay/prescription for retail 34-day supply;$120 copay/prescription for retail or mail order 90-day supply	In-Network copay plus an additional 25% of the approved amount	
	Non-preferred brand-name drugs	$80 copay/prescription for retail 34-day supply; $240 copay/prescription for retail or mail order 90-day supply	In-Network copay plus an additional 25% of the approved amount	
	Generic and preferred brand-name specialty Drugs	20% coinsurance of the approved amount, but no more than $150 copay/prescription for retail or mail order 30-day supply	In-Network copay plus an additional 25% of the approved amount	Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of network.
	Nonpreferred brand-name specialty drugs	20% coinsurance of the approved amount, but no more than $300 copay/prescription for retail or mail order 30-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	$200 copay/visit	$200 copay/visit	Copay waived if admitted or for an accidental injury.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Mileage limits apply
	Urgent care	$50 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

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 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 30 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)
- Hearing aids
- 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.)

- Chiropractic Care
- Coverage provided outside the United States. See (http://www.messa.org)
- 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	**$1,600**
Specialist copayment	**$50**
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	$1,600
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,460**

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

The plan's overall deductible	**$1,600**
Specialist copayment	**$50**
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	$1,600
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

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

The plan's overall deductible	**$1,600**
Specialist copayment	**$50**
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	$1,600
Copayments	$100
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,750**

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.

Langua,ge services

If you., or s·orneo11e you're helping, 111eeds assistance, you haive the right to get help and i11forrnation in your language at no cost. To talkIto am inlte,p:reter, call MESSA'.s Member Service Ce1nter alt S00.336.0013 or TTY 888.445.5614.

Si usted, o alguien a quien usted estii ayudando, necesita a:sistenda, tiene derec ho a obtener ayuda e informaci6n en su idioma sin ,costo a guno. Para habllar ,con u i,nterprete, lllame ,al numero telef6nico de servici,os para miembros de MESSA, que a,parece en la parte trasera de su tarjeta.

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falls Sie oder jemand, dem Sie helfen, Unte,rstutztmg benotigen, haben Sie d'as Recht kostenlose Hilfe und 1:nformationen in lhrer Sprache zu erlhalten. Um mit einem Dolm-etscher zu sip,re,che11, rufen Sie bite die Nummer der MESSA-Mitgliederlbetre·uung aufder Ruckseite ihr,er Karte an. Se tu o qualcuno che stai ,a,iutando avete bisogno di assistenza, hai ,iidiritto di oUener,e gratu· amente aiL1to e informazioni nellla tua lingua. P,er parlare con un interprete, chiama ii numero ,del servizio membri MESSA presente sulliretro della tua tessera.

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Ktmg ikaw, o ang iyong tinutuhmgan, ay naingangailangan ng tulong, may karapa,tan kang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang interpre·ter, tumawag s.a numero para sa, m.ga serbisyo sa miiYembro ng MESSA na nasa likuran ng iyong card.

Important disclosure

MESSA and Blue Cross Bll1.1e Shied of Michigan,(BCBSM:) comply with federal ,civill rights laws and do not ,discriminate on the ba,,sis of race, color, nationa! origin, age, disability, or sex. MESSA and BCBSM pro11Ji,de free auxillia.y aids and services to peo1Pie with disabillities to communi,cate effectijvely with us, including qualified sign languag,e inte,rpreters. If you need assistance, call MESSA's Membe,rService Center at 800.336.0013 or TTY 888.445.5614.

Ilf you need help filing a grievance, IV ESSA's general counsel is availlabfe to help you. If yo,u bellieve that MESSA or BCBSM fai e-d to provLde s.ervices or ,discriminated in another way on the basis of race, color., national origin, age, disahility, or sex, you can file a grievan,ce in person, or by mail, phone, fax or email: General Counsel!, MESSA, P.O. Box. 2560,.East Lansing, MI 48826-2560, 800.292.49J..O, TTY: 888.445.5613,.fax: 517.203.2909 or CivilRights-GeneralCou ns.el@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 maiil, phone or email: U.S.. Department of Health &.H'uman Services, 200 Independence Ave, S.W., Washington, D.C. 20201, 800.368.1019, TIO: 800.537.7697, or OCRComplaint@l.hs.gov.