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 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 800-336-0013 to request a copy.

| Important Questions | Answers | | Why This Matters: |
|---|---|---|---|
| | In-Network | Out-of-Network | |
| What is the overall deductible? | $500 Individual/ $1,000 Family | $1,000 Individual/ $2,000 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) | $2,500 Individual/ $5,000 Family | $5,000 Individual/ $10,000 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 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 | $20 copay/office visit | 40% coinsurance | Copay waived if seen on same date of injury. |
| | Specialist visit | $20 copay/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. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.messa.org | Generic or prescribed over-the-counter drugs (Tier 1) | $10 copay/prescription for retail 34-day supply, $25 copay/prescription for 90-day supply; deductible does not apply | $10 copay/prescription for 34-day supply, $25 copay/prescription for 90-day supply plus an additional 25% of BCBSM approved amount for the drug; deductible does not apply | Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. Your Prescription drug coverage has a separate out-of-pocket limit of $2,000/$4,000. Mail order drugs are not covered out-of-network. |
| | 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 supply; deductible does not apply | 20% coinsurance with $40 min and $80 max/prescription for 34-day supply, 20% coinsurance with $100 min and $200 max/prescription for 90-day supply plus an additional 25% of BCBSM approved amount for the drug; deductible does not apply | |

| 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) | |
| | 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 supply; deductible does not apply | 20% coinsurance with $60 min and $100 max/prescription for 34-day supply, 20% coinsurance with $150 min and $250 max for 90-day supply plus an additional 25% of BCBSM approved amount for the drug; deductible does not apply | |
| 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 | $50 copay/visit | $50 copay/visit | Copay waived if admitted or accidental injury. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Mileage limits apply. |
| | Urgent care | $25 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 |
| If you need mental health, behavioral health, or substance use disorder services | 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 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. |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | None |
| | Childbirth/delivery facility services | 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 help recovering or have other special health needs | Home health care | 20% coinsurance | 20% coinsurance | Preauthorization is required. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Physical, Occupational, Speech therapy is limited to a combined maximum of 60 visits per member, per calendar year. |
| | Habilitation services | 20% coinsurance | 40% 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 | 20% coinsurance | 20% coinsurance | Preauthorization is required. Limited to a maximum of 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 | Preauthorization is required. Unlimited visits. |
| If your child needs dental or eye care | 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)
- 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.)**

- 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, copayments, or coinsurance, or benefits not otherwise covered.
- Infertility treatment
- Non-Emergency care when travelling 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 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.

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 | $500 |
| Specialist copayment | $20 |
| 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 | $500 |
| Copayments | $100 |
| Coinsurance | $1,900 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Peg would pay is | $2,500 |

### 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 | 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 | $7,400 |
|---|---|

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $470 |
| Coinsurance | $990 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Joe would pay is | $1,960 |

### 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 | 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 | $1,900 |
|---|---|

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $190 |
| Coinsurance | $110 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $800 |

The plan would be responsible for the other costs of these EXAMPLE covered services.

## 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. للتحدّث 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.