



## MESSA Balance+ & Balance+ RX



PPO

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](http://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 <u>deductible</u> ?	\$1,600 Individual/ \$3,200 Family	\$3,200 Individual/ \$6,400 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> services are covered before you meet your <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 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 ( <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> ).
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)	\$4,000 Individual/ \$8,000 Family	\$8,000 Individual/ \$16,000 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> ?	<u>Premiums</u> , <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 ( <a href="http://www.messa.org">http://www.messa.org</a> ) 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 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>referral</u> .



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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /office visit	40% <u>coinsurance</u>	Members 18 years and older have access to Virtual Primary Care visits by a BCBSM selected vendor.
	<u>Specialist</u> visit	\$50 <u>copay</u> /office visit	40% <u>coinsurance</u>	None
	<u>Preventive care/ screening/ immunization</u>	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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	May require <u>preauthorization</u>
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.bcbsm.com/druglists">www.bcbsm.com/druglists</a>	Generic or prescribed over-the-counter drugs	\$10 <u>copay</u> /prescription for retail 34-day supply; \$30 <u>copay</u> /prescription for retail or mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	<u>Preauthorization</u> , 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 <u>copay</u> /prescription for retail 34-day supply; \$120 <u>copay</u> /prescription for retail or mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	
	Non-preferred brand-name drugs	\$80 <u>copay</u> /prescription for retail 34-day supply; \$240 <u>copay</u> /prescription for retail or mail order 90-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	
	Generic and preferred brand-name specialty Drugs	20% <u>coinsurance</u> of the approved amount, but no more than \$150 <u>copay</u> /prescription for retail or mail order 30-day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	<u>Preauthorization</u> , step therapy and quantity limits may apply to select drugs. <u>Preventive</u> drugs covered in full. 90-day supply not covered out of network.

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)	
	Nonpreferred brand-name specialty drugs	20% <u>coinsurance</u> of the approved amount, but no more than \$300 <u>copay</u> /prescription for retail or mail order 30-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
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit	\$200 <u>copay</u> /visit	<u>Copay</u> waived if admitted or for an accidental injury.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Mileage limits apply
	<u>Urgent care</u>	\$50 <u>copay</u> /visit	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required
	Physician/surgeon fee	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> 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

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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Physician certification required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Physical, Speech and Occupational Therapy is limited to a combined maximum of 30 visits per member, per calendar year.
	<u>Habilitation services</u>	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> .
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Physician certification required. Limited to 120 days per member per calendar year
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Physician certification required. Unlimited visits.
<b>If your child needs dental or eye care</b> 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](http://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](http://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](http://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](mailto: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**

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*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 <u>plan's</u> overall <u>deductible</u>	\$1,600
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,600
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$800
<u>What isn't covered</u>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,460</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,600
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,600
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$100
<u>What isn't covered</u>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,320</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,600
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,600
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$50
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,750</b>

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.



## 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 تساعد بحاجة إلى المساعدة، فمن حقك الحصول على المساعدة والمعلومات بلغتك بدون أي كلفة. للتحدث إلى مترجم، اتصل بالرقم المخصص الموجود على ظهر بطاقتك MESSA لخدمات أعضاء.

如果您，或是您正在協助的對象，需要協助，您有權利免費以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.

যদি আপনাকে বা আপনাকে সাহায্য করছেন এমন কারো সাহায্যের প্রয়োজন হয়, তাহলে ককারণা খরচ ছাড়াই আপনার ভাষায় সহায়তা ও তথ্য পাওয়ার অধিকার রয়েছে। ককারণা কিতাধারীর সারণ্য কখ্যা বেরত, আপনার কার্ডের কপছরন পিত্ত MESSA সিসম পদররমববার নম্বরর কে করুন।

যদি আপনার বা আপনাকে সাহায্য করছেন এমন কারো সাহায্যের প্রয়োজন হয়, তাহলে ককারণা খরচ ছাড়াই আপনার ভাষায় সহায়তা ও তথ্য পাওয়ার অধিকার রয়েছে। ককারণা কিতাধারীর সারণ্য কখ্যা বেরত, আপনার কার্ডের কপছরন পিত্ত MESSA সিসম পদররমববার নম্বরর কে করুন।

Jeśli Ty lub osoba, której pomagasz, potrzebujesz 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 usluge 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](mailto:CivilRights-GeneralCounsel@messa.org).

You can also file a civil rights complaint with the Office for Civil Rights on the web at [OCRCComplaint@hhs.gov](mailto:OCRCComplaint@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 [OCRCComplaint@hhs.gov](mailto:OCRCComplaint@hhs.gov).