MESSA Choices

Medical plan coverage

MESSA®

Good health. Good business. Great schools.

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MESSA Choices – Helpful information

Health care benefits provided under the MESSA Choices Preferred Provider Organization (PPO) plan are underwritten by Blue Cross Blue Shield of Michigan (BCBSM) and 4 Ever Life.

This booklet is designed to help you understand your coverage.

To view your specific deductibles, copayments and coinsurance levels, go to **www.messa.org** to access your member account.

Upon registration, you can check your deductible progress, review benefit information and access medical and prescription claims data.

If you prefer to talk with a real person about your specific coverage, call the MESSA Member Service Center at 800.336.0013 or TTY 888.445.5614. Your employer's business office can also provide the plan information.

Occasionally, state or federal law requires changes to medical coverage. When such changes occur, this booklet will be revised and posted at **www.messa.org**. This document is not a contract. It is intended to be a summary description of benefits. Every effort has been made to ensure the accuracy of this information. However, if statements in this description differ from the applicable coverage documents, then the terms and conditions of those documents will prevail.

How to contact us

Give us a call

MESSA Member Service Center – 800.336.0013 or TTY 888.445.5614

Let's talk in person

Meet with a member service specialist at our East Lansing office, weekdays 8 a.m. to 5 p.m. Our address is 1475 Kendale Blvd., East Lansing.

Let us call you

Log in to your member account at **www.messa.org** and send us a secure message if you'd like a MESSA team member to contact you.

By mail

MESSA
1475 Kendale Blvd.
P.O. Box 2560
East Lansing, MI, 48826-2560

Tips to help us serve you better

Here are some important tips to remember:

1. Have your ID card handy so you can provide your enrollee ID/contract number. If you are writing to us, include this information in your correspondence.
2. To ask if a particular service is covered, please have your physician provide you with the five-digit procedure code. If your planned procedure does not have a code, obtain a complete description of the service as well as the diagnosis.
   NOTE: Benefits cannot be guaranteed over the phone.
3. To inquire about a claim, please provide the following:
   - Patient's name
   - Provider's name (such as the doctor, hospital or supplier)
   - Date the patient was treated
   - Type of service (for example, an office visit)
   - Charge for the service
4. When writing to us, please send copies of your bills, other relevant documents, and any correspondence you have received from us. Make sure you keep your originals.
5. Include your daytime telephone number as well as your enrollee ID/contract number on all correspondence.

Your ID card

Your MESSA/BCBSM identification (ID) card is your key to receiving quality health care. Your card will look similar to the one shown here.

The numbers on your personal ID card will be different from the one illustrated above.

Enrollee name is the name of the person who holds the contract.

Enrollee ID identifies your records in our files The **alpha prefix** preceding the enrollee ID number identifies that you have coverage through MESSA.

Issuer identifies you as a Blue Cross Blue Shield of Michigan member. The number 80840 identifies the industry as a health insurance carrier.

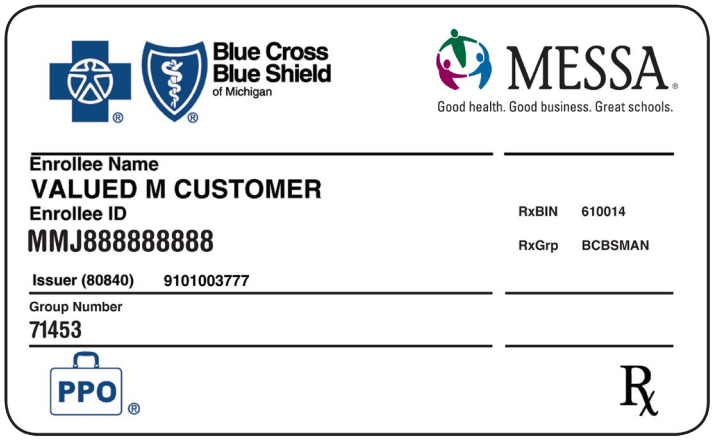
Group number tells us you are a MESSA/BCBSM group member.

The suitcase tells providers about your travel benefits.

On the back of your ID card, you will find:

- A magnetic strip which will help providers process your claims. It includes information from the front of the card and the enrollee's date of birth. It does not include any benefit or health information.
- MESSA's toll-free member services/inquiries telephone number to call us when you have a claim or benefit inquiry, as well as other important telephone numbers.

Your ID card is issued once you enroll for coverage. It lets you obtain services covered under MESSA. Only the enrollee's name appears on the ID card. However, the cards are for use by all covered members and dependents.



Here are some tips about your ID card:

- Carry your card with you at all times to help avoid delays when you need medical attention.
- If you or anyone in your family needs an ID card, you can:
  - Register for or log in to your member account at www.messa.org to request a card (two will be sent per request)
  - Log in to your member account to view and use a virtual ID card
  - Call the MESSA Member Service Center to request a card
- Call the MESSA Member Service Center if your card is lost or stolen. You can still receive service by giving the provider your Enrollee ID number to verify your coverage.

Only you and your eligible dependents may use the cards issued for your plan. Lending your card to anyone not eligible to use it is illegal and subject to possible fraud investigation and termination of coverage.

Explanation of Benefit (EOB) statements

You will receive an EOB form each time we process a claim under your enrollee ID/contract number. The EOB is not a bill. To help avoid overpayment, it is a good idea to wait until you receive an EOB before paying a medical bill.

An EOB includes:

- member name
- family member who received services
- contract number (enrollee ID #)
- claim number
- date of service
- type of service/provider
- total charge
- ineligible amount
- remark code(s) explaining variance
- allowable amount
- deductible amount applied on this claim
- balance
- percentage paid by MESSA
- benefit payment
- date provider payment made
- description of remark codes
- helpful information about MESSA programs

Please check your EOBs carefully. If you see an error, please contact your provider first. If they cannot correct the error, call the MESSA Member Service Center.

Go paperless! Log in to your member account and click "Manage account" to sign up for online EOB statements.

If you think your provider is intentionally billing for services you did not receive or that someone is using your ID card illegally, contact the anti-fraud toll-free hotline at **1.866.211.4475**. Your call will be kept strictly confidential. By working together, we can help keep health care costs down.

Eligibility guidelines

Who is eligible for coverage?

The following individuals are eligible to become members of the Michigan Education Special Services Association (MESSA) and may apply for coverage:

- Any active, associate, service associate, retiree, or student member of the Michigan Education Association (MEA) as defined in the MEA bylaws
- Any member of a bargaining unit in an educational agency in which a local association of MEA is the recognized bargaining agent and has negotiated MESSA benefits for its members
- Any administrator employed by an educational agency in which a local association of the MEA is a recognized bargaining agent and has negotiated MESSA benefits for its members
- Any other eligible individual as defined in the MESSA bylaws

Applying for coverage

An application is required if you are:

- Enrolling for the first time
- Changing coverage for yourself or your dependents
- Changing school districts
- Covering dependent children age 19 or older

We will review your application for coverage to determine if you, your spouse and your dependents are eligible for coverage based on the terms of your plan. If you, your group or someone applying for coverage on your behalf commits fraud or makes an intentional misrepresentation of material fact in completing the application, your coverage may be rescinded as stated in the section on When Coverage Ends.

Eligible dependents

If you are covered, your eligible dependents include:

- Your spouse
- Your children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until a maximum of the end of the calendar year of their 26th birthday

NOTE: Your child's spouse and your grandchildren are not covered under this plan.

- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are developmentally disabled or physically handicapped, dependent upon you for a majority of their support and who are incapable of self-sustaining employment by reason of their developmental disability or physical handicap. (Under no circumstances will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA to obtain the appropriate form to continue coverage.
- Your children beyond the end of the calendar year of their 26th birthday (if covered under this program at the end of the calendar year of their 26th birthday and continuously thereafter) who are full-time students and dependent on you for a majority of their support.
- We will continue coverage when the dependent student takes a leave of absence from school or changes to part-time status due to serious illness or injury. The continuation of coverage will last until the earlier of the following dates occurs:
  - Up to one year after the first day of a medically necessary leave of absence or change in status
  - The date on which the student's coverage would otherwise terminate
  - To qualify for continued coverage, the student's attending physician must certify in writing that the student suffers from a serious illness or injury and that the leave or change in status is medically necessary. The student must continue to meet all other MESSA eligibility requirements.

Eligible dependents

continued...

- Your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year and are continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

You may also request group coverage for yourself or your dependents within 60 days of either of the following events:

- Your Medicaid coverage or your dependents' CHIP coverage (Children's Health Insurance Program) is terminated due to loss of eligibility.
- You or your dependent becomes eligible for premium subsidies.

It is your responsibility to notify MESSA and your employer:

- Of any change in your employment status
- When you wish to add a spouse and/or dependent(s)
- Of any change to a dependent's eligibility for coverage
- When a spouse and/or dependent is no longer eligible as defined above

Special health care coverage guidelines apply to you and your spouse at age 65 during your active school employment. You should contact your school business office or MESSA for complete details. The Social Security Administration should be contacted regarding Medicare enrollment 120 days prior to attaining age 65.

When coverage begins

- If you are a new employee and enroll for coverage within 31 days following the date you became eligible (your date of employment or the day following completion of the eligibility waiting period, whichever is later), your coverage will be effective on the date you became eligible. This date is verified by your employer.
- During open enrollment, the effective date of coverage for all new applications and coverage changes will be that date approved by MESSA and verified by your employer.
- If your application is submitted at any other time, your coverage will be effective on the first day of the month following approval of your application by MESSA.
- Each dependent will be eligible for coverage on the later of the date on which your coverage begins or the date he/she becomes an eligible dependent if enrolled within 31 days. If your application for dependent coverage is submitted at any other time, coverage will be effective on the first day of the month following approval of your application by MESSA.
- Each sponsored dependent will be eligible for coverage on the later of the date on which your coverage begins or the first day of January following the date he/she becomes an eligible dependent.

When coverage ends

Your MESSA Choices coverage, and that of your covered dependents, continues until one of the following circumstances occurs:

- **Termination of employment** - Coverage will end on the last day of the month in which you terminate employment.
- **Nonpayment of contributions** - Coverage will end on the last day of the month preceding the month for which the required contribution has not been remitted to MESSA.
- **Termination of employer's participation** - Coverage will end on the last day of any month in which your employer ceases to participate under the MESSA BCBSM Group Agreement.
- **Rescission** – Coverage may be terminated back to the effective date of your coverage if you, your group, or someone seeking coverage on your behalf performed an act, practice, or omission that constitutes fraud, or has made an intentional misrepresentation of fact to us or another party which results in you or a dependent obtaining or retaining coverage with MESSA or the payment of claims under this or another MESSA plan. You will be provided with prior notice of the rescission, if required under the law. You will be required to repay us for our payment for any services you received during this period.
- **Member no longer eligible** - Coverage will end on the last day of the month in which a member no longer meets the eligibility criteria described in this section.
- **Dependent no longer eligible** - Coverage will end on the date a dependent no longer meets the eligibility criteria described in this section.

NOTE: An ex-spouse may be continued beyond the date of the divorce if the divorce decree stipulates that the member must provide health coverage for his/her ex-spouse. The member will be required to pay the sponsored dependent contribution in addition to his/her normal contribution. Coverage will terminate on either the date the ex-spouse remarries or the date which is 12 months following the date of the divorce, whichever is earlier.

- **Termination of the MESSA/BCBSM group agreement** - Coverage will end on the date the Group Agreement terminates.
- **Medicare elected as primary** - If you continue active school employment beyond age 65 and elect Medicare as your primary coverage, your coverage under MESSA Choices will end on the first day of the month following the date of your election. A spouse age 65 or older who obtains coverage through an active employee may also elect Medicare as his/her primary coverage; the spouse's coverage under MESSA Choices will end on the first day of the month following such an election.

NOTE: If you cease active work or leave school employment, inquire as to what arrangements, if any, may be made to continue coverage. Also see the following "Continuation of Health Care Coverage." Contact MESSA for additional information.

Continuation of health care coverage

Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA is a federal law that extends the opportunity for group coverage to members who no longer qualify as members of a group. For COBRA purposes, coverage includes the benefits described in this booklet. The continued coverage is available to covered employees, their spouses and dependent children (all of whom are referred to as "qualified beneficiaries") whose coverage would otherwise end upon the occurrence of a "qualifying event," including:

- The death of the covered employee
- The termination (other than by reason of gross misconduct) or reduction of hours of the covered employee's employment
- The divorce or legal separation of the covered employee
- A dependent child ceasing to be a dependent child under the generally applicable provisions of the program
- The covered employee becoming entitled to Medicare benefits.

You and your dependent(s) must pay the required contribution, if any, for the continued coverage. Your employer will inform you of the monthly contribution to be paid.

In the event of your divorce or legal separation or if your dependent child ceases to be eligible as a dependent under the program, you or your dependent must notify the plan administrator (your employer) of the occurrence of the qualifying event within 60 days after it occurs or the date coverage is terminated, whichever is later.

Continued coverage must be elected within an election period that cannot end before the date which is 60 days after the later of (1) the date coverage is terminated and (2) the date you receive notice of the right to continue coverage.

The continued coverage will begin on the date of the qualifying event and end when the first of the following events occurs:

- The date which is 36 months (18 months in the case of the termination or reduction in hours of the covered employee's employment) after the qualifying event

NOTE: You, or a covered dependent, may be able to extend continuation of coverage from 18 months to 29 months if the Social Security Administration has determined (or determines) that you, or a covered dependent, has been totally disabled since the date of eligibility for continuation coverage or within 60 days following that date. Continuation coverage may be extended only if the Social Security Administration makes its determination within 18 months of the qualifying event.

- The first day for which timely payment for the qualifying beneficiary is not made to the plan
- The date upon which your employer terminates participation under the MESSA/BCBSM Group Agreement that provides the benefits described in this booklet

Continuation of health care coverage

continued...

- The date the qualified beneficiary becomes covered under any other group plan that is not maintained by your employer (other than a plan containing limitations or exclusions with respect to a pre-existing condition of the qualified beneficiary)
- The date the qualified beneficiary becomes entitled to benefits under Medicare

If during an established COBRA period of continuance, another qualifying event occurs that also entitles you or your dependent(s) to COBRA continuation, coverage may be extended, but not beyond the date which is 36 months from the date of the initial qualifying event.

If a qualified beneficiary's continued coverage ends due to the expiration of the 36-month, 29-month or 18-month maximum continuation period, the qualified beneficiary may enroll in any conversion health plan available.

Surviving family

Your employer can provide you with more information concerning how these COBRA health plan continuation rights apply to you and your family members and how to elect continued coverage under the plan in the event of a qualifying event.

Your dependents who are covered under the MESSA Choices Plan on the date of your death should contact MESSA for information regarding continuation of coverage.

MESSA®
Good health. Good business. Great schools.

Save money: Choose in-network doctors and other providers

MESSA Choices has different levels of benefits for in-network and out-of-network services. The plan has an in-network deductible and an out-of-network deductible.

You will pay less out-of-pocket and receive more comprehensive benefits (such as preventive care) when you see in-network providers.

Approved amount

In-network and out-of-network doctors and facilities who "participate" with Blue Cross Blue Shield of Michigan will accept the approved amount as payment in full (after deductible, copayments and coinsurance where applicable). More than 80 percent of Michigan physicians are in the network. PPO networks save you money because those hospitals and doctors agree to accept discounted fees. This also helps save your group on its premiums.

Nonparticipating doctors and facilities have no such agreements and you are responsible for payment to them for charges in excess of the approved amounts.

We offer the largest network of doctors, hospitals and other health care specialists who have agreed to accept our approved amount as payment in full for covered services. That means:

- Your in-network costs are limited to applicable in-network deductibles, copayments and coinsurance.

To find an in-network provider:

1. Ask your doctor or other medical provider if he or she is in our network
2. Go to **www.messa.org** to use our "Find a doctor" feature
3. Call MESSA at 800.336.0013 or TTY 888.445.5614

Out-of-network providers

When you receive care from a provider who is not part of the PPO network, without a referral from a PPO provider, your care is considered out-of-network. For most out-of-network services, you have higher deductibles and coinsurance. Out-of-network expenses do not count towards the in-network deductible or total out-of-pocket maximum.

Most free preventive care services, including annual checkups and well-baby visits, are only covered when provided by an in-network provider.

What you should know about referrals

Want to visit an out-of-network provider? Start with a referral.

Your in-network provider should refer you to another in-network provider when available. If one is not available, your provider should refer you to a participating provider. This is a provider who accepts BCBSM. The in-network referring physician should complete a PPO program referral form for the claim to be paid as in-network. A referral is only valid when it is obtained before the referred services are provided. The referring physician should complete the form and provide copies to you and the physician to whom you were referred.

With a referral to an out-of-network provider:

- Your out-of-network deductible is waived (you may have an in-network deductible to satisfy)
- Your out-of-network coinsurance may be waived (in-network coinsurance may apply)
- No claim forms
- Referrals are good for one year
- You may still be responsible for charges over the allowed amount

NOTE: Most preventive care services are not covered out-of-network.

No referral? Be prepared to pay more.

You can use an out-of-network provider without a referral, but you will pay your out-of-network deductible and coinsurance. You may also pay additional charges above the approved amount and need to complete and submit claim forms to MESSA.

You also may be responsible for payment at the time of service in addition to filing your own claim. MESSA will reimburse up to the approved amount, less the out-of-network deductible and coinsurance.

Out-of-network, “participating” providers

If you choose to receive services from an out-of-network provider, you can still limit your out-of-pocket costs if the provider participates in BCBSM’s Traditional plan.

When you use participating providers:

- You will pay the out-of-network deductible and coinsurance.
- You will not have to submit a claim. The provider will bill us directly for your services.
- You will not be billed for any differences between our approved amount and their charges.

Remember, some services, such as most of your preventive care services, are not covered out-of-network.

Out-of-network, “nonparticipating” providers

Nonparticipating providers are providers who are not in the PPO network and do not participate with us. If you receive services from a nonparticipating provider, in addition to the out-of-network deductible and coinsurance, you may also be responsible for any charges above the approved amount. Providers who do not participate with us are not required to accept the approved amount as payment in full for covered services. **The additional charges may be significant**.

When you use nonparticipating providers, **you may be responsible for payment at the time of service** in addition to filing your own claim. MESSA will reimburse the approved amount, less the out-of-network deductible and coinsurance.

Pre-Admission Review requirements

In-network and participating hospitals

The hospital will take care of this requirement for you.

Out-of-network, nonparticipating hospitals

If you are using a nonparticipating hospital, then you, your doctor or hospital must request prior approval for all elective (nonemergency) admissions to a hospital.

- You, your doctor or hospital must call MESSA for a review of the admission request. The toll-free telephone number is 1.800.336.0022 or TTY 888.445.5614. MESSA will review your doctor's request and determine whether your admission will be authorized under our medically necessary criteria. MESSA will determine the number of days initially approved and will send written notice of the decision to you.

Emergency hospital admissions

Advance approval is not required for emergency admissions. However, your doctor or hospital must notify MESSA within 48 hours of the start of your admission, or within 72 hours of the start of the admission if it begins on a weekend (5 p.m. Friday through 9 a.m. Monday) or a holiday. MESSA will then determine the number of days to be authorized under our medically necessary criteria, and will provide written notice to you.

Requesting additional days

The hospital or your doctor can request additional days beyond the days initially approved. Whenever possible, such requests should be made up to 48 hours before the end of the days initially approved. MESSA will let you and the hospital know if the request for additional days has been approved.

If the extension is not approved and your hospital admission exceeds the number of days determined by MESSA to be medically necessary, you will be responsible for the following:

- Charges for inpatient hospital room and board
- Other charges for medical services and supplies furnished by the hospital
- Physician charges for inpatient hospital visits
- Any other charges related to the days not approved

Requesting approval after admission

If the hospital or your physician fails to get approval before you are admitted, MESSA will still review a request, either while you are in the hospital or after your discharge. The disadvantage is that you will not know before the admission whether the care is covered.

Appealing a nonapproved admission or extension

Your doctor may appeal all decisions by requesting a review by MESSA.

Receiving services without prior approval

If you were given prior notice of MESSA's denial of benefits before the admission began, or if you accepted such liability by entering into a prior agreement with your doctor or the hospital, you will be responsible for all charges (both hospital and doctor) resulting from the admission.

You have access to personal support from a MESSA nurse

Managing a chronic condition can be overwhelming. There's a lot you need to know in order to properly keep your condition in check, avoid medical crises and improve your quality of life.

That's where MESSA's member education and support programs can help. MESSA nurses can provide one-on-one guidance and help you manage your health.

MESSA has individual member education and support programs for asthma, diabetes and cardiovascular health, each with its own dedicated nurse who works with members and provides important information, motivation and support to help them reach their health goals. The cardiovascular health program, for example, helps members identify and track key cardiovascular metrics such as blood pressure, blood sugar and cholesterol.

Each of the programs provide to members and their dependents:

- Access to specially-trained nurses who provide personalized one-on-one support
- Educational materials such as books, fliers, pamphlets and videos
- Tips for improving the patient-doctor relationship

Personalized help is just a phone call away. For more information on MESSA's member education and support programs, call 800.336.0022, prompt 3 or TTY 888.445.5614.

What happens if your PPO physician leaves the network

Your physician is your partner in managing your health care. However, physicians retire, move or otherwise cease to be affiliated with our PPO network. If this happens, your physician should notify you that he or she is no longer in the PPO network. If you have difficulty choosing another physician, please contact the MESSA Member Service Center for assistance. If you wish to continue care with your current physician, a customer service representative will explain the financial costs to you when services are performed by a physician who is no longer in the PPO network.

Medical care while traveling in the U.S.

As a MESSA member, your health coverage goes with you when you travel. You have access to the state and national networks of Blue Cross Blue Shield of Michigan, the underwriter of MESSA medical plans. If you want to keep costs down, it's important to see an in-network doctor. All services are subject to your plan's deductible.

For emergency or accidental injuries:
Call 911 or go to the nearest hospital or emergency room. Emergency care is always covered anywhere within the U.S. Just make sure you have your MESSA/Blue Cross insurance card on you.

If you or a covered dependent require hospitalization, you must contact MESSA Pre-Admission Review at 800.336.0022, prompt 7 or TTY 888.445.5614, within 48 hours of admission, or within 72 hours if admission occurs on a weekend.

For urgent care that requires attention within 48 hours:
All urgent care is covered, no matter where you are. Just make sure you have your MESSA/Blue Cross card with you. Call 800.336.0013 or TTY 888.445.5614 or visit www.messa.org to find a doctor or hospital.

For non-emergency care:
Find an in-network doctor at www.messa.org or call 800.336.0013 or TTY 888.445.5614. When you visit an in-network doctor, you will only pay the rate the local Blue Cross Blue Shield plan negotiated with that doctor for your care. In most cases, you shouldn't have to pay more than what you usually pay for care.

If you see an out-of-network doctor, your share of the costs might go up and you might not be covered for all services.

Try to use a participating pharmacy if needed. Most major U.S. retail pharmacies are in our network. Present your MESSA insurance card for convenience and savings.

Medical care while traveling outside the U.S.

You have access to doctors and hospitals with the BlueCard Worldwide Program. You may want to visit the BlueCross Worldwide program's website (www.bluecardworldwide.com) to find in-network providers prior to your departure.

For emergency care or accidental injuries:
Go to the nearest hospital. Make sure you have your MESSA/Blue Cross card. Emergency and urgent care is covered no matter where you are. If you're not sure where to go to get help, contact BlueCard Worldwide at 1.800.810.2583 (or call collect at 1.804.673.1177). They can direct you to the nearest medical facility.

You may need to pay for all costs at the time you get care, but we'll reimburse you once you arrive back home. You can submit a claims reimbursement form and send it with any itemized bills to MESSA.

For non-emergency care:
Call BlueCard Worldwide at 1.800.810.2583 to find a hospital or authorized health care provider. You may have to pay for all costs upfront. You can submit a claims reimbursement form and send it with any itemized bills to MESSA.

Contacting MESSA from outside the U.S.
From the U.S. Virgin Islands, Puerto Rico, Canada and Guam: 1.800.380.3251.

From other foreign countries: 1.517.999.4557. You will need the United States international access code of the country you are calling from.

Don't forget your medications
When you're traveling, knowing you have access to medication when you need it is always a great relief. Make sure you have enough prescription medication to last until you return.

If you need to obtain a prescription medication while traveling, you will need to pay for the prescription out of pocket and submit a reimbursement request.

Deductibles

The amount you pay for health care services before your health insurance begins to pay. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31.

There may be separate in-network and out-of-network deductibles depending on your plan. Two or more members must meet the family deductible. If one member of the family meets the individual deductible, but the family deductible has not been met, MESSA will pay for covered services for that member only. Covered services for the remaining family members will be paid when the full deductible has been met.

There is a 4th quarter carryover provision for **in-network** deductible amounts accrued during the final three months of each calendar year (October-December). Those deductible amounts "carry forward" to help satisfy the **in-network** deductible the following calendar year.

Some services do not have a network. Examples include but are not limited to: home health care agencies, hospice, durable medical equipment (DME), etc. In these cases the out-of-network deductible is waived and the in-network deductible and coinsurance apply.

Copayments

A copayment is a fixed amount you pay for a medical visit or prescription until the out-of-pocket maximum is reached.

Coinsurance

Coinsurance is a fixed percentage you pay for a specific medical service after your deductible is met.

Annual out-of-pocket maximums

Out-of-pocket maximum is the most you have to pay for covered services in a calendar year, including deductibles, prescription copayments and coinsurance.

Charges in excess of the approved amount and charges for services not covered under the plan do not count toward your out-of-pocket maximums

For specific information on your deductibles, copayments and coinsurance, refer to your personalized medical plan highlights available in the Members Only section of www.messa.org. You may also call the MESSA Member Services Center at 800.336.0013 or TTY 888.445.5614.

NOTE: There is no 4th quarter carryover of out-of-pocket maximums.

All services listed below must be medically necessary and performed by a payable provider.

Acupuncture

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Copayment may apply - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, copayment, coinsurance), log in to your member account at messa.org.		

We pay for acupuncture treatment with an approved diagnosis when performed by an M.D. or D.O. in an inpatient or outpatient hospital setting, ambulatory surgery facility or physician's office.

Allergy services

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Copayment may apply - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, copayment, coinsurance), log in to your member account at messa.org.		

We pay for the following allergy testing and therapy services performed by, or under the supervision of, a physician:

- Survey, including history, physical exam, and diagnostic laboratory studies
- Intradermal, scratch and puncture tests
- Patch, photo, insufflate, and provocative antigen tests
- Procedures to desensitize patients to antigens or haptens
- Ultrasound, radiotherapy and radiothermy treatments
- Injections of anti-allergen, antihistamine, bronchodilator or antispasmodic agents

We do not pay for: fungal or bacterial skin tests (such as those given for tuberculosis or diphtheria) or environmental studies, evaluation or control.

Ambulance

What **You** Pay for Covered Services	
There is currently no network; in-network (IN) benefits apply	
Participating Provider	**Nonparticipating Provider**
- IN deductible - IN coinsurance may apply after deductible is met	- IN deductible - IN coinsurance may apply after deductible is met - Charges in excess of approved amount
For your plan's specific benefit levels (deductible, coinsurance), log in to your member account at messa.org.	

Covered services include transportation by professional ambulance to, or from, the nearest hospital equipped to furnish treatment. Within the United States and Canada, benefits are also available for emergency transportation by air ambulance to the nearest hospital equipped to furnish treatment. In all cases, only the patient's transportation is covered. Ambulance transportation is not covered for patient or family convenience or for physician preference.

Anesthesia

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

Services for giving anesthesia to patients undergoing covered services are payable to either:

- A physician, other than the physician performing the service
- A physician who orders and supervises anesthetist services
- A certified registered nurse anesthetist (CRNA) in an:
  - Inpatient hospital setting
  - Outpatient hospital setting
  - Participating ambulatory surgery facility

  CRNA services must be performed under the medical direction of a licensed physician or under the general supervision of a licensed physician responsible for anesthesiology services.

If the operating physician gives the anesthesia, the services are included in our payment for the surgery.

Audiologist services

What **You** Pay for Covered Services	
There is currently no network; in-network (IN) benefits apply	
Participating Provider	**Nonparticipating Provider**
- IN deductible - IN coinsurance may apply after deductible is met	- IN deductible - IN coinsurance may apply after deductible is met - Charges in excess of approved amount
For your plan's specific benefit levels (deductible, coinsurance), log in to your member account at messa.org.	

We pay for covered services performed by an audiologist who is licensed or legally qualified to perform these services. To be payable, services performed by an audiologist must be referred by a provider who is legally authorized to prescribe the services.

Autism Spectrum Disorders – Rendered by a Board-Certified Behavior Analyst (BCBA)

Autism Spectrum Disorders (ASD) include Autistic Disorder, Asperger's Disorder and Autism Pervasive Developmental Disorder Not Otherwise Specified.

What **You** Pay for Covered Services	
There is currently no network; in-network (IN) benefits apply	
Participating Provider	**Nonparticipating Provider**
- IN deductible - Copayment may apply - IN coinsurance may apply after deductible is met	- IN deductible - Copayment may apply - IN coinsurance may apply after deductible is met - Charges in excess of approved amount
For your plan's specific benefit levels (deductible, copayment, coinsurance), log in to your member account at messa.org.	

Autism Spectrum Disorders – Rendered by PhD

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Copayment may apply - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, copayment, coinsurance), log in to your member account at messa.org.		

Applied Behavior Analysis services

Applied Behavior Analysis (ABA) is an evidence-based treatment for ASD that is covered under this plan. ABA services are available for children through the age of 18.

Prior authorization of ABA services is required. If prior authorization is not obtained, the member will be responsible for 100% of the cost of treatment. A member seeking ABA services is required to go to a BCBSM-Approved Autism Evaluation Center (AAEC) for the evaluation, diagnosis and/or confirmation of a diagnosis of an ASD and have a high level treatment plan developed. If ABA services are recommended by the AAEC, the member can seek services from a Board-Certified Behavior Analyst (BCBA), who will then develop a detailed treatment plan specific to ABA treatment. The BCBA **must** obtain prior approval from BCBSM, otherwise the member will be responsible for the cost of treatment.

To be covered, ABA services must be provided or supervised by:

- A Board-Certified Behavior Analyst registered with BCBSM (all BCBAs registered with BCBSM are considered in-network), or
- a fully licensed psychologist, so long as the services performed are commensurate with the psychologist's formal university training and supervised experience

Additional covered services

Additional covered services for ASD include:

- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech Therapy (ST)
- Other medical services used to diagnose and treat autism, including nutrition counseling and genetic testing as recommended by the treatment plan.

NOTE: When the above PT, OT, ST services are included in an ASD treatment plan they are not subject to the combined annual maximum of 60 visits.

Services and conditions not covered

- Conditions such as Rett's Disorder and Childhood Disintegrative Disorder
- Any treatment that is not a covered benefit by us, including, but not limited to, sensory integration therapy and chelation therapy

Definitions for autism-related services can be found in the Glossary of Health Care Terms of this booklet.

Bone marrow transplants

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- Not covered
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

We pay for a maximum of two transplants per member per condition. When medically necessary, and not experimental or investigational, we pay for services for and related to:

- Allogeneic transplants
- Autologous transplants

We also pay for antineoplastic drugs or the use of off-label drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

Bone marrow transplant—covered conditions

Allogeneic transplants are covered to treat:

- Acute lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute myelogenous leukemia (high-risk, refractory or relapsed patients)
- Aplastic anemia (acquired or congenital, e.g., Fanconi's anemia or Diamond-Black fan syndrome)
- Beta-thalassemia
- Chronic myeloid leukemia
- Hodgkin's disease (high-risk, refractory or relapsed patients)
- Myelodysplastic syndromes
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high-risk, refractory or relapsed patients)
- Osteopetrosis
- Severe combined immune deficiency disease
- Wiskott-Aldrich syndrome
- Sickle cell anemia (ss or sc)
- Myelofibrosis
- Multiple myeloma
- Primary amyloidosis (AL)
- Glanzmann thrombasthenia
- Paroxysmal nocturnal hemoglobinuria
- Kostmann's syndrome
- Leukocyte adhesion deficiencies
- X-linked lymphoproliferative syndrome
- Primary, secondary and unspecified thrombocytopenia (e.g., megakaryocytic thrombocytopenia)
- Mantle cell lymphoma
- Congenital leukocyte dysfunction syndromes
- Congenital pure red cell aplasia
- Chronic lymphocytic leukemia
- Mucopolysaccharidoses (e.g., Hunter's, Hurler's, Sanfilippo, Maroteaux-Lamy variants) in patients who are neurologically intact
- Mucolipidoses (e.g., Gaucher's disease, metachromatic leukodystrophy, globoid cell leukodystrophy, adrenoleukodystrophy) for patients who have failed conventional therapy (e.g., diet, enzyme replacement) and who are neurologically intact
- Renal cell CA
- Plasmacytomas
- Other conditions for which treatment is non-experimental

Autologous transplants are covered to treat:

- Acute lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Germ cell tumors of ovary, testis, mediastinum, retroperitoneum
- Hodgkin's disease (high-risk, refractory or relapsed patients)
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high-risk, refractory or relapsed patients)
- Multiple myeloma
- Primitive neuroectodermal tumors
- Ewing's sarcoma
- Medulloblastoma
- Wilms' tumor
- Primary amyloidosis
- Rhabdomyosarcoma
- Mantle cell lymphoma
- Other conditions for which treatment is non-experimental

Bone marrow transplant—covered services & exclusions

Allogeneic transplants

- Blood tests on first degree relatives to evaluate them as donors (if the tests are not covered by their insurance)
- Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established and the transplant is preapproved.
- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood, if the donor is:
  - A first degree relative and matches at least four of the six important HLA genetic markers with the patient; or
  - Not a first degree relative but matches five of the six important HLA genetic markers with the patient. (In case of sickle cell anemia (ss or sc) or beta thalassemia, the donor must be an HLA-identical sibling.)

NOTE: Harvesting and storage will be covered if it is not covered by the donor's insurance, but only when the recipient of harvested material is a MESSA member.

- High-dose chemotherapy and/or total body irradiation
- Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord blood
- T-cell depleted infusion
- Donor lymphocyte infusion
- Hospitalization

Autologous transplants

- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell pheresis) and storage of bone marrow and/or peripheral blood stem cells
- Purging and/or positive stem cell selection of bone marrow or peripheral blood stem cells
- High-dose chemotherapy and/or total body irradiation
- Infusion of bone marrow and/or peripheral blood stem cells
- Hospitalization

NOTE: A tandem autologous transplant is covered only when it treats germ cell tumors of the testes or multiple myeloma.

We do not pay for:

- Services rendered to a transplant recipient who is not a MESSA member
- Services rendered to a donor when the donor's health care coverage will pay
- Services rendered to a donor when the transplant recipient is not a MESSA member
- Expenses related to travel or lodging for the donor or recipient
- An autologous tandem transplant for any condition other than germ cell tumors of the testes or multiple myeloma
- An allogeneic tandem transplant
- Search of an international donor registry
- The routine harvesting and storage costs of bone marrow, peripheral blood stem cells or a newborn's umbilical cord blood if not intended for transplant within one year
- Any other services or admissions related to any of the above named exclusions

Certified nurse midwife services – see Maternity care

Chemotherapy

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

We pay for chemotherapeutic drugs that are:

- Ordered by a physician for the treatment of a specific type of malignant disease
- Provided as part of a chemotherapy program
- Approved by the Food and Drug Administration for use in chemotherapy

NOTE: If the FDA has not approved the drug for the specific disease being treated, MESSA and BCBSM's Medical Policy departments determine the appropriateness of the drug for that disease by using the following criteria:

- *Current medical literature must confirm that the drug is effective for the disease being treated.*
- *Recognized oncology organizations must generally accept the drug as treatment for the specific disease.*
- *The physician must obtain informed consent from the patient for the treatment.*

We also pay for:

- Physician services for the administration of the chemotherapy drug, except those taken orally
- The chemotherapy drug administered in a medically approved manner
- Other FDA-approved drugs classified as:
  - Anti-emetic drugs used to combat the toxic effects of chemotherapeutic drugs
  - Drugs used to enhance chemotherapeutic drugs
- Drugs to prevent or treat the side effects of chemotherapy treatment
- Administration sets, refills and maintenance of implantable or portable pumps and ports

Chiropractic services

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Copayment may apply - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, copayment, coinsurance), log in to your member account at messa.org.		

We pay for spinal manipulation to treat misaligned or displaced vertebrae of the spine. Certain other services such as x-rays, traction and custom orthotics are also covered. There is an annual limit to the number of covered visits. Call MESSA Member Services at 800.336.0013 or TTY 888.445.5614 to find out how many visits are covered under your plan.

Colonoscopy – Preventive

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- No cost to you	- Not covered	- Not covered

One colonoscopy per covered adult per calendar year is payable without cost share. Subsequent colonoscopies performed during the same calendar year would fall under the Colonoscopy – Medically Necessary section.

Colonoscopy – Medically necessary

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

Consultations

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Copayment may apply - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, copayment, coinsurance), log in to your member account at messa.org.		

We pay for inpatient and outpatient consultations when your physician requires assistance in diagnosing or treating your condition. The assistance is required because of the special skill and knowledge of the consulting physician or professional provider.

Cosmetic surgery

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

Cosmetic surgery is payable only for:

- Correction of deformities present at birth. Exception: Congenital deformities of the teeth are not covered
- Correction of deformities resulting from cancer surgery, including reconstructive surgery after a mastectomy
- Conditions caused by accidental injuries
- Traumatic scars

NOTE: Physician services for cosmetic surgery are not payable when services are primarily performed to improve appearance.

Dental services

What **You** Pay for Covered Services	
There is currently no network; in-network (IN) benefits apply	
Participating Provider	**Nonparticipating Provider**
- IN deductible - IN coinsurance may apply after deductible is met	- IN deductible - IN coinsurance may apply after deductible is met - Charges in excess of approved amount
For your plan's specific benefit levels (deductible, coinsurance), log in to your member account at messa.org.	

Covered services include dental treatment by a licensed dentist or dental surgeon required for:

- accidental injury to sound natural teeth
- the removal of cysts and tumors of the mouth and jaw
- extraction of impacted teeth (secondary to dental insurance)

For non-covered services, please see the Exclusions and Limitations section of this booklet.

Diagnostic services

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

We pay for physician services to diagnose disease, illness, pregnancy or injury through such tests as:

- Thyroid function
- Electrocardiogram
- Electroencephalogram
- Electromyogram
- Nerve conduction
- Pulmonary function studies

The services must be prescribed by a physician.

Diagnostic laboratory and pathology services

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

We pay for laboratory and pathology exams needed to diagnose a disease, illness, pregnancy or injury. The services must be prescribed by a physician and may be performed at a physician's office, hospital, or sent to a laboratory.

NOTE: If the physician has a laboratory perform these services, it must be an in-network laboratory for you to receive in-network benefits. You will be required to pay the out-of-network deductible and coinsurance when services are provided by an out-of-network laboratory unless your physician refers you to an out-of-network laboratory for tests.

Durable Medical Equipment (DME)

What **You** Pay for Covered Services	
There is currently no network; in-network (IN) benefits apply	
Participating Provider	**Nonparticipating Provider**
- IN deductible - IN coinsurance may apply after deductible is met	- IN deductible - IN coinsurance may apply after deductible is met - Charges in excess of approved amount
For your plan's specific benefit levels (deductible, coinsurance), log in to your member account at messa.org.	

Covered services include the rental cost, not to exceed the purchase price, of durable medical equipment when prescribed by a physician and purchased from a recognized DME provider. Call MESSA for more information. Benefits include items such as hospital beds and/or wheelchairs. Items such as air purifiers, air conditioners and exercise equipment are not covered.

Emergency room (ER) or urgent care – Medical emergency

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- ER or urgent care copayment - Deductible - If copayment is waived, coinsurance may apply after the deductible is met	- ER or urgent care copayment - IN Deductible	- ER or urgent care copayment - IN Deductible - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, copayment, coinsurance), log in to your member account at messa.org.		

A medical emergency is defined as "a condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately."

If you seek care for treatment of an accidental injury or medical emergency at an out-of-network hospital or urgent care center, then in-network benefits will apply. The copayment will be waived if the patient is treated for an accidental injury or is admitted to the hospital; in-network coinsurance may apply.

Emergency room (ER) or urgent care – Non-emergency treatment at ER or urgent care

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- ER or urgent care copayment - Deductible - If copayment is waived, coinsurance may apply after the deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, copayment, coinsurance), log in to your member account at messa.org.		

We pay for facility services and physician(s) for the initial exam and treatment in a hospital emergency room or urgent care center.

End Stage Renal Disease (ESRD)

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

Physician services are payable for the treatment of ESRD. Services may be provided in the hospital, a freestanding facility (designated by BCBSM to provide such services) or in the home.

Physician services for the treatment of ESRD are covered in coordination with Medicare. It is important that individuals with ESRD apply for Medicare Part B coverage through the Social Security Administration. MESSA is the primary payer to Medicare for up to 33 months (this includes the three-month waiting period from the time the member is diagnosed with ESRD), if the member is under age 65 and eligible for Medicare because of ESRD.

Call your local Social Security Administration or visit **www.medicare.gov** for assistance with enrollment. You may also call MESSA at 800.336.0013 or TTY 888.445.5614 with questions about your benefits.

Hearing care services

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

Hearing-related services performed by an M.D. or D.O. are covered under the standard medical care benefit portion of your plan.

Audiology services

What **You** Pay for Covered Services	
There is currently no network; in-network (IN) benefits apply	
Participating Provider	**Nonparticipating Provider**
- IN deductible - IN coinsurance may apply after deductible is met	- IN deductible - IN coinsurance may apply after deductible is met - Charges in excess of approved amount
For your plan's specific benefit levels (deductible, coinsurance), log in to your member account at messa.org.	

We pay for covered services performed by an audiologist (who is licensed or legally qualified to perform these services). Covered expenses include an audiometric examination for either ear, or both ears, that:

- Is prescribed by a physician-specialist
- Is performed by a physician-specialist, audiologist or hearing aid specialist or dealer
- Includes tests for measuring hearing perception relation to air conduction, bone conduction, speech reception threshold, and speech discrimination
- Includes a summary of findings

Hearing aids

What **You** Pay for Covered Services	
There is currently no network; in-network (IN) benefits apply	
Participating Provider	**Nonparticipating Provider**
- IN deductible - IN coinsurance may apply after deductible is met	- IN deductible - IN coinsurance may apply after deductible is met - Charges in excess of approved amount
For your plan's specific benefit levels (deductible, coinsurance), log in to your member account at messa.org.	

There is a maximum benefit, adjusted annually based on the Consumer Price Index (CPI), for a hearing aid for each ear during a 36-month period. An audiometric examination, a hearing aid evaluation, and a conformity test for each ear will be paid during a 36-month period. In addition, the plan covers a hearing aid for each ear when required due to accidental injury sustained while covered by this plan.

The hearing aid(s) must be:

- Designed to be worn in the ear, behind the ear or on the body
- Prescribed by a physician-specialist, audiologist, or hearing aid specialist or dealer based on the most recent audiometric examination and hearing aid evaluation test
- The make and model prescribed by the physician-specialist, audiologist, or hearing aid specialist or dealer; and
- Provided by a hearing aid specialist or dealer

For hearing aids purchased out-of-state, the approved amount may not be based on CPI. It is to your advantage to choose a participating provider. Participating providers should not require payment at the time of service. Participating providers must bill Blue Cross Blue Shield of their state and accept the payment as payment in full.

Hemodialysis

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

Services are payable when provided in the hospital outpatient department, freestanding facility or in a home hemodialysis program.

Home health care

What **You** Pay for Covered Services	
There is currently no network; in-network (IN) benefits apply	
Participating Provider	**Nonparticipating Provider**
- IN deductible - IN coinsurance may apply after deductible is met	- IN deductible - IN coinsurance may apply after deductible is met - Charges in excess of approved amount
For your plan's specific benefit levels (deductible, coinsurance), log in to your member account at messa.org.	

This program provides an alternative to long-term hospital care by offering coverage for care and services in the patient's home. Services must be prescribed by the patient's attending physician, be medically necessary and be provided by a home health care agency.

To qualify for this benefit, a covered person must have physician certification assuring home health care is a medically necessary alternative to hospital confinement. The services are available based on a 30-day benefit period. The benefit period may be renewed with certification from your physician. Covered services include:

- Part-time skilled nursing care (full-time care is not covered) rendered by a registered nurse or a licensed practical nurse
- Medical care rendered by a home health aide or nurse's assistant under the direct supervision of a registered nurse
- Medical supplies other than drugs and medicines requiring a written prescription from a physician
- Rental of medical equipment (not to exceed purchase price)
- Physical therapy, occupational therapy, speech therapy, social service guidance, and nutritional guidance provided by a home health care agency
- Hospital services and supplies related to the injury or illness which required or would have required the hospital confinement and would normally be provided by the hospital

NOTE: Meals, general housekeeping services and custodial care are not covered.

Hospice care

What **You** Pay for Covered Services	
There is currently no network; in-network (IN) benefits apply	
Participating Provider	**Nonparticipating Provider**
- No cost to you	- Charges in excess of approved amount

Hospice benefits allow covered terminally ill patients to spend their final days at home or in a special hospice facility as approved by MESSA. You may apply for hospice benefits after discussion with, and with a referral by, your attending physician.

Benefits become available when:

- The covered patient is terminally ill with a life expectancy of 12 months or less as certified in writing by the attending physician or
- You are a covered dependent of the terminally ill patient meeting the requirements described above

Hospice care continued...

Hospice care services are payable for four 90-day periods. The following criteria must be met:

- The patient or his or her representative elects hospice care services in writing. This written statement must be filed with a participating hospice program.
- The following certifications are submitted to us:

First 90-day period

- A written certification stating that the patient is terminally ill, signed by the:
  Medical director of the hospice program **or**
  Physician of the hospice interdisciplinary group **and** attending physician, if the patient has one

Second 90-day period

(Submitted no later than two days after this 90-day period begins):

- The hospice must submit a **second** written certification of terminal illness signed by the:
  Medical director of the hospice **or**
  Physician of the hospice interdisciplinary group

Third 90-day period

(Submitted no later than two days after this 90-day period begins):

- The hospice must submit a **third** written certification of terminal illness signed by the:
  Medical director of the hospice **or**
  Physician of the hospice interdisciplinary group

Fourth 90-day period

(Submitted no later than two days after this 90-day period begins):

- The hospice must submit a **fourth** written certification of terminal illness signed by the:
  Medical director of the hospice **or**
  Physician of the hospice interdisciplinary group

The patient, or his or her representative, must sign a "Waiver of Benefits" form acknowledging that the patient has been given a full explanation of hospice care. This waiver confirms the patient's (or family's) understanding that regular benefits for conditions related to the terminal illness are not in force while hospice benefits are being used.

*NOTE: Our benefits for conditions **not** related to the terminal illness remain in effect.*

Payable services

Before electing to use hospice care services, the patient and his or her family are eligible to receive counseling, evaluation, education and support services from the hospice staff. These services are limited to a 28-visit maximum.

When a patient elects to use hospice care services, regular MESSA coverage for services in connection with the terminal illness and related conditions, are replaced with the following:

- Inpatient care provided by a hospice inpatient unit, hospital or skilled nursing facility contracting with the hospice program
- Occasional respite care of up to five days duration, within a 30 calendar day period, to relieve family members or other persons caring for the member at home
- Part-time skilled nursing care (full-time care is not included) by a registered nurse or licensed practical nurse
- Medical supplies
- Rental of medical equipment (not to exceed purchase price)
- Physical therapy, emotional support services, homemaker or home health aide services (provided by or on behalf of the hospice program)
- Charges for physician services
- Bereavement counseling for the family after the patient's death. This bereavement counseling benefit ends:
  - 12 months after the date of the first family unit counseling session or
  - 18 months after the date the hospice benefit began

Hospital care

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

Human organ transplants*

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- No cost to you if performed during the benefit period	- Deductible - Coinsurance applies after deductible is met	- Not covered
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

***Preapproval is mandatory.** We will not pay for services, admissions or lengths of stay that are not preapproved. Services must be rendered in a designated cancer center.

Benefit period

All payable human organ transplant services, except anti-rejection drugs, must be provided during the benefit period that begins five days before, and ends one year after, the organ transplant.

When performed in a designated facility, we pay for transplantation of the following organs:

- Combined small intestine-liver
- Heart
- Heart/lung(s)
- Liver
- Lobar lung
- Lung(s)
- Pancreas
- Partial liver
- Kidney-liver
- Simultaneous pancreas-kidney
- Small intestine (small bowel)
- Multivisceral transplants (as determined by MESSA)

Human organ transplants continued...

Other transplant-related coverage

When directly related to the transplant, we pay for:

- Facility and professional services
- Anti-rejection drugs and other transplant-related prescription drugs, during and after the benefit period, as needed.
- Immunizations against certain common infectious diseases during the first 24 months post-transplant are covered. We pay for immunizations as recommended by the Advisory Committee on Immunizations Practices (ACIP). This also includes kidney transplants, but not cornea or skin.
- Medically necessary services needed to treat a condition arising out of the organ transplant surgery if the condition:
  - Occurs **during** the benefit period and
  - Is a **direct** result of the organ transplant surgery
- Reimbursement up to $10,000 for eligible travel and lodging expenses during the initial transplant surgery, which includes:
  - Transportation to and from the designated transplant facility for the patient and another person eligible to accompany the patient (two persons if the patient is a child under the age of 18 or if the transplant involves a living-related donor) and
  - Reasonable and necessary costs of lodging for the person(s) eligible to accompany the patient

NOTE: In certain limited cases, we may consider return travel needed for an acute rejection episode to the original transplant facility. The condition must be emergent and must fall within the benefit period. The cost of the travel must still fall under the $10,000 maximum for travel and lodging.

Organ acquisition

We pay for:

- Cost of acquiring the organ (the organ recipient must be a MESSA member). This includes but is not limited to:
  - Surgery to obtain the organ
  - Storage of the organ
  - Transportation of the organ
- Living donor transplants such as partial liver, lobar lung, small bowel and kidney transplants that are part of a simultaneous kidney transplant
- Payment for covered services for a donor if the donor does not have transplant services under any health care plan

NOTE: We will pay the BCBSM approved amount for the cost of acquiring the organ.

Human organ transplants continued...

Limitations and Exclusions

We do not pay for the following for specified organ transplants:

- Services that are not benefits under this plan
- Services rendered to a recipient who is not a MESSA member
- Living donor transplants not listed herein
- Anti-rejection drugs that do not have FDA approval
- Transplant surgery and related services performed in a non-designated facility. You must pay for the transplant surgery and related services you receive in a non-designated facility unless medically necessary and approved by the BCBSM/MESSA medical director
- Transportation and lodging costs for circumstances other than those related to the initial transplant surgery and hospitalization
- Items that are not considered directly related to travel and lodging (examples include, but are not limited to the following: mortgage, rent payments, furniture rental, dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, cash advances, lost wages, tips, toys, household products, alcoholic beverages, flowers, greeting cards, stationery, stamps, gifts, household utilities (including cell phones), maids, babysitters or daycare services, services provided by family members, reimbursement of food stamps, mail/UPS services, internet service, and entertainment (such as cable television, books, magazines and movie rentals))
- Routine storage cost of donor organs for the future purpose of transplantation
- Services prior to your organ transplant surgery, such as expenses for evaluation and testing, unless covered elsewhere in your plan
- Experimental transplant procedures

Human organ transplants (kidney, cornea and skin)

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

Services for kidney, cornea and skin transplants are covered as standard benefits and are not limited to specific transplant facilities. We pay for services performed to obtain, test, store and transplant the organs. We will also pay for covered services for a donor if the donor does not have transplant benefits under any health care plan.

Mammography – Preventive

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- No cost to you	- Deductible - Coinsurance applies after deductible is met	- OON Deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

MESSA covers one 2D mammogram per covered adult per calendar year without cost share. A digital breast tomosynthesis or 3D mammogram is performed at the same time as a 2D exam and with the same system. If billed in conjunction with the 2D mammogram, MESSA also covers one 3D mammogram per covered adult per calendar year without cost share. Subsequent mammograms performed during the same calendar year would fall under the **Mammography – Medically Necessary** section.

NOTE: Although most preventive services by an out-of-network provider are not covered, 2D mammography is an exception to that rule. It is to your advantage to choose an in-network provider as 3D mammography by an out-of-network provider is not covered.

Mammography – Medically necessary

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

MESSA covers traditional 2D mammography as well as 3D mammography when medically necessary. A digital breast tomosynthesis or 3D mammogram is performed at the same time as a 2D exam and with the same system.

Maternity care – Delivery, ultrasounds and certain labs

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

Maternity care – Prenatal and postnatal

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- No cost to you	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

You have coverage for prenatal care office visits and obstetrical services including delivery. Maternity care benefits also are payable when provided by a certified nurse midwife at a BCBSM-approved birth center.

Medical Case Management (MCM) claims

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

Medical case management is a program designed to assist you if you are diagnosed with a catastrophic illness or injury. There is no cost to enroll in the program. Once enrolled, a nurse case manager will help ensure you are directly involved in the management of your health care. The nurse will support you and may help you obtain necessary health care.

Program eligibility is determined on a case-by-case basis in accordance with medically necessary criteria. Approval of benefits will be based on an objective review of your medical status, current and projected treatment plans, long-term cost implications and the effectiveness of care.

The following medical conditions are examples of what may be considered for medical case management:

- Pancreatitis
- Major head trauma
- Spinal cord injury
- Amputations
- Multiple fractures
- Severe burns
- Neonatal high-risk infants
- Severe stroke
- Multiple sclerosis
- Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- Acquired immune deficiency syndrome (AIDS)
- Crohn's disease
- Cancer

Medical Case Management is designed to give you and your family members flexibility and direct involvement in the management of your health care.

NOTE: Prior approval must be obtained from MESSA before benefits can begin.

If you have any questions regarding MCM, please contact MESSA at 1.800.441.4626 or TTY 888.445.5614.

Medical supplies

What **You** Pay for Covered Services	
There is currently no network; in-network (IN) benefits apply	
Participating Provider	**Nonparticipating Provider**
- IN deductible - IN coinsurance may apply after deductible is met	- IN deductible - IN coinsurance may apply after deductible is met - Charges in excess of approved amount
For your plan's specific benefit levels (deductible, coinsurance), log in to your member account at messa.org.	

We pay for many medical supplies and dressings when ordered by a physician for the treatment of a specific medical condition (e.g. test strips and lancets for the treatment of diabetes). Contact MESSA Member Services at 800.336.0013 or TTY 888.445.5614 to inquire whether coverage is available for your medical supplies. To receive reimbursement for supplies purchased out-of-pocket, you must have a prescription from your physician and a receipt of the item(s) purchased. Follow the instructions under **How to File a Medical Claim**.

Mental health and substance abuse services

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Copayment may apply - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, copayment, coinsurance), log in to your member account at messa.org.		

We pay for mental health and substance abuse services that are medically necessary and provided by an eligible provider.

Eligible providers

- Medical doctors (M.D.)
- Doctors of osteopathy (D.O.)
- Fully licensed psychologists (Ph.D., D. Psy., F.L.P.)
- Clinical Licensed Master's Social Worker (CLMSW)
- Certified nurse practitioners (C.N.P.)*
- Licensed Professional Counselor (LPC)
- Hospital-based mental health facilities*
- Outpatient psychiatric care facilities*
- Hospital-based and freestanding residential substance abuse facilities*
- Outpatient substance abuse treatment programs*

*For coverage regarding services by a nonparticipating provider, contact MESSA for more information.

NOTE: For Michigan MSWs who are members of the Academy of Certified Social Workers (ACSW), contact MESSA for coverage information.

Nutritional counseling – Registered Dietitian

What **You** Pay for Covered Services	
There is currently no network; in-network (IN) benefits apply	
Participating Provider	**Nonparticipating Provider**
- IN deductible - IN coinsurance may apply after deductible is met	- IN deductible - IN coinsurance may apply after deductible is met - Charges in excess of approved amount
For your plan's specific benefit levels (deductible, coinsurance), log in to your member account at messa.org.	

Nutritional counseling is available for specific medical conditions, subject to lifetime visit limits. There is no network for a Registered Dietitian, so in-network benefits would apply. Contact MESSA Member Services at 800.336.0013 or TTY 888.445.5614 prior to receiving counseling in order to determine your benefits.

Nutritional counseling – Physician

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

Nutritional counseling is available for specific medical conditions, subject to lifetime visit limits. These visits must be performed by an M.D. or D.O. Contact MESSA Member Services at 800.336.0013 or TTY 888.445.5614 prior to receiving counseling in order to determine your benefits.

Nutritional counseling – Preventive

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- No cost to you	- Not covered	- Not covered

Six preventive nutritional counseling visits per covered member per calendar year are payable without cost share.

Obstetrics – see Maternity care

Occupational Therapy – see Therapy services

Office, outpatient, home physician visits and consultations

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Copayment may apply - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, copayment, coinsurance), log in to your member account at messa.org.		

Oncology clinical trials*

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- Not covered
For your plan's specific IN benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

***Preapproval is mandatory.** We will not pay for services, admissions or lengths of stay that are not preapproved. Services must be rendered in a designated cancer center. If one or more in-network or participating BCBSM providers participate in an approved clinical trial, we may require members to participate in the trial through one of those providers unless the trial is conducted outside of Michigan. Preapproval is good only for one year after it is issued.

We pay for a maximum of two single transplants per member for the same condition.

We cover specified bone marrow and peripheral blood stem cell transplants, their related services and FDA-approved antineoplastic drugs to treat stages II, III and IV breast cancer and all stages of ovarian cancer when they are provided pursuant to an approved phase II or III clinical trial. Coverage of antineoplastic drugs is not limited or precluded when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

Immunizations against certain common infectious diseases during the first 24 months post-transplant are covered. We pay for immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP).

Covered services

Autologous Transplants

- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell phereses) and storage of bone marrow and/or peripheral blood stem cells
- Purging or positive stem cell selection of bone marrow or peripheral blood stem cells
- High-dose chemotherapy and/or total body irradiation
- Infusion of bone marrow and/or peripheral blood stem cells
- Hospitalization

Allogeneic Transplants

- Blood tests to evaluate donors (if the tests are not covered by their insurance)
- A search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established.
- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cells and/or umbilical cord blood

  NOTE: Harvesting and storage will be covered if it is not covered by the donor's insurance, but only when the recipient of the harvested material is a MESSA member.
- High-dose chemotherapy and/or total body irradiation
- T-cell depleted infusion
- Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord blood
- Donor lymphocyte infusion
- Hospitalization

Travel and lodging

We will pay up to a total of $5,000 for travel and lodging expenses directly related to preapproved services rendered during an approved clinical trial. The expenses must be incurred during the period that begins with the date of preapproval and ends 180 days after the transplant. However, these expenses will not be paid if your coverage is no longer in effect.

Oncology clinical trials continued...

We will pay the expenses of an adult patient and another person, or expenses of a patient under the age of 18 and expenses for two additional people. The following per day amounts apply to the combined expenses of the patient and persons eligible to accompany the patient:

- $60 per day for travel
- $50 per day for lodging

NOTE: These daily allowances may be adjusted periodically. Please contact MESSA for the current maximums allowed.

Routine patient costs

We cover the routine costs of items and services related to Phase I, II, III or IV clinical trials whose purpose is to prevent, detect or treat cancer or other life-threatening disease or condition. The member receiving the items or services must be a qualified individual as defined herein.

We pay for all items and services related to an approved clinical trial if they are covered under this plan for members who are not participants in an approved clinical trial.

We do not pay for:

- The experimental or investigational item, device or service itself
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the trial participant
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Harvesting and storage costs of bone marrow, umbilical cord blood and/or peripheral blood stem cells if not intended for transplant within one year
- Services for a transplant recipient who is not a MESSA member
- Services rendered to a donor when the transplant recipient is not a MESSA member
- Services rendered to a donor when the donor's health care coverage will pay
- Non-health care related services and/or research management (such as administrative costs)
- Search of an international donor registry
- Items that are not considered directly related to travel and lodging (examples include, but are not limited to the following: mortgage, rent payments, furniture rental, dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, cash advances, lost wages, tips, toys, household products, alcoholic beverages, flowers, greeting cards, stationery, stamps, gifts, household utilities (including cellular telephones), maids, babysitter or day care services, services provided by family members, reimbursement of food stamps, mail or UPS services, internet connection, and entertainment (such as cable television, books, magazines and movie rentals))
- Any facility, physician or associated services related to any of the above named exclusions

Osteopathic manipulations

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Copayment may apply - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, copayment, coinsurance), log in to your member account at messa.org.		

We pay for osteopathic manipulative therapy performed by an osteopathic physician. Services are covered up to a benefit maximum of 38 visits per member, per calendar year.

Physical therapy – see Therapy services

Prescription drugs

Please refer to your MESSA Prescription Drug Program Booklet available at www.messa.org, or call MESSA Member Services at 800.336.0013 or TTY 888.445.5614.

Certain specialty pharmaceuticals such as infused or injected medications administered by your doctor are paid under your medical plan instead of your prescription drug program. For more info go to: https://www.messa.org/Members/Pharmacy-Prescriptions/Walgreens-Specialty-Pharmacy

Preventive care services

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- No cost to you	- Not covered	- Not covered

MESSA health plans include coverage for in-network preventive care services performed by an M.D. or D.O. including:

- One health maintenance exam per covered adult per calendar year
- Two preventive gynecological exams per calendar year
- Specific adult and child immunizations
- Well-baby and child visits according to current preventive care recommendations of the Affordable Care Act

For additional information, please contact your doctor or call MESSA Member Services at 800.336.0013 or TTY 888.445.5614.

Preventive Care – List of covered screenings as recommended by the U.S. Preventive Services Task Force

Pediatric Preventive Care – Guidelines from the American Academy of Pediatrics and Bright Future

Childhood Immunizations* - Recommended Immunization Schedule for ages 0-6

Childhood Immunizations* - Recommended Immunization Schedule for ages 7-18

Adult Immunizations* - Recommended Adult Immunization Schedule

* Immunizations provided by a Public Health Department or at a MESSA-sponsored event are paid as in-network. Certain adult immunizations are covered at participating pharmacies. Call MESSA for additional information.

Private duty nursing

What **You** Pay for Covered Services	
There is currently no network; in-network (IN) benefits apply	
Participating Provider	**Nonparticipating Provider**
- IN deductible - Minimum 10% IN coinsurance may apply after deductible is met	- IN deductible - Minimum 10% IN coinsurance may apply after deductible is met - Charges in excess of approved amount
For your plan's specific benefit levels (deductible, coinsurance), log in to your member account at messa.org.	

We pay for private duty nursing services in your home or in a hospital if it is:

- Skilled care given by a professional registered nurse or licensed practical nurse (requiring, for example: administration of I.V. drugs, ventilator care, etc.)
- Medically necessary and required on a 24-hour basis
- Given in a hospital, because the hospital lacks intensive or cardiac care units or has no space in such units
- Provided by a nurse who is not related to or living with the patient

All progress notes must be submitted with the claim form.

Prosthetic and orthotic devices

What **You** Pay for Covered Services	
There is currently no network; in-network (IN) benefits apply	
Participating Provider	**Nonparticipating Provider**
- IN deductible - IN coinsurance may apply after deductible is met	- IN deductible - IN coinsurance may apply after deductible is met - Charges in excess of approved amount
For your plan's specific benefit levels (deductible, coinsurance), log in to your member account at messa.org.	

We pay for prosthetic and orthotic devices when required because you do not have a certain body part or the device would improve your body's function. Devices must be prescribed by a physician. Repairs or replacements are covered due to wear and tear or growth.

Benefits include, but are not limited to:

- External breast prostheses following a mastectomy, including three post-surgical brassieres each calendar year; additional brassieres are covered if there is a significant change in body weight or for hygienic reasons
- Two wigs each calendar year for hair loss for certain medical conditions
- Artificial eyes, ears, nose, larynx, limbs
- Orthopedic shoes meeting MESSA guidelines
- One pair of prescription eyeglasses or contact lenses if you do not have an organic lens or following cataract surgery or accidental injury while covered by this plan
- Prefabricated custom-made orthotic devices
- External cardiac pacemakers
- Maxillofacial prosthesis when approved; these devices may be provided by dentists

Radiology services

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

Diagnostic – We pay for physician services to diagnose disease, illness, pregnancy or injury through:

- X-ray
- Ultrasound
- Radioactive isotopes
- Computerized Axial Tomography
- Magnetic Resonance Imaging for specific diagnoses (you should call MESSA for information about any restrictions)

Therapeutic – We pay for physician services to treat medical conditions by X-ray, radon, radium, external radiation or radioactive isotopes.

The services must be prescribed by a physician.

Residential psychiatric treatment*

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Copayment may apply - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, copayment, coinsurance), log in to your member account at messa.org.		

***Preapproval is mandatory.** We will not pay for services, admissions or lengths of stay that are not preapproved.

We pay for the following:

- Services provided by facility staff
- Individual psychotherapeutic treatment
- Family counseling for members of a patient's family
- Group psychotherapeutic treatment
- Prescribed drugs given by the facility in connection with the member's treatment plan

Limitations and exclusions

We do not pay for:

- Staff consultations required by a facility's or program's rules
- Marital counseling
- Services that are not focused on improving the member's functioning
- Services that are primarily for the purpose of maintaining long-term gains made by the member while in another treatment program
- A residential program that is a long-term substitute for a member's lack of available supportive living environment within the community
- A residential program that serves to protect family members and other individuals in the member's living environment

Residential psychiatric treatment continued...

Limitations and exclusions continued

- Services to treat a disorder that is not amendable to favorable modification, according to generally accepted professional, evidence-based literature, such as certain personality disorders or certain types of intellectual impairment
- Services or treatment that are cognitive in nature or supplies related to such services or treatment
- Services, treatment or supplies that are court-ordered or related to a court order
- Transitional living centers such as half-way and three-quarter-way houses
- Therapeutic boarding schools
- Milieu therapies, such as wilderness programs, supportive houses or group homes
- Domiciliary foster care
- Custodial care
- Treatment or programs for sex offenders or perpetrators of sexual or physical violence
- Services to hold or confine a member under chemical influence when the member does not require medical treatment
- A private room or apartment
- Non-medical services including, but not limited to: enrichment programs, dance therapy, art therapy, music therapy, equine therapy, yoga and other movement therapies, ropes courses, guided imagery, consciousness raising, socialization therapy, social outings, and educational or preparatory courses or classes. These services may be paid as part of a treatment program, but they are not payable separately.

Skilled nursing care

What **You** Pay for Covered Services	
There is currently no network; in-network (IN) benefits apply	
Participating Provider	**Nonparticipating Provider**
- IN deductible - IN coinsurance may apply after deductible is met	- IN deductible - IN coinsurance may apply after deductible is met - Charges in excess of approved amount
For your plan's specific benefit levels (deductible, coinsurance), log in to your member account at messa.org.	

A skilled nursing facility provides comprehensive inpatient care of either a short or extended duration and is operated under the general direction of a licensed physician. This program provides benefits for skilled care in a skilled nursing facility only for the period that is necessary for the proper care and treatment of the patient, up to a maximum of 120 days per member, per calendar year. **This benefit does not include custodial or domiciliary care.**

Speech Therapy – see therapy services

Surgical services

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

Payment includes:

- Physician's surgical fee
- Pre- and post-surgery medical care provided by the surgeon while the patient is in the hospital
- Visits to the attending surgeon for the usual pre- and post-surgery care

Multiple surgeries

When multiple surgeries are performed on the same day by the same physician, payment is as follows:

- Multiple surgeries through the same incision by the same physician are considered related; therefore, we will pay our approved amount of the more difficult procedure
- Multiple surgeries through different incisions by the same physician are paid as follows:
  - Our approved amount for the more costly procedure and
  - 50% of the approved amount for the less costly procedure(s)

NOTE: Determination of the more or less difficult procedure is based on the approved amount.

In-network and participating providers follow these guidelines and agree to accept our payment as payment in full. However, out-of-network (nonparticipating) providers may bill you for the difference between the approved amount, less any required deductible, copayments and coinsurance, and billed charges.

Restrictions

- Dental surgery is payable only for:
  - Multiple extractions or removal of unerupted teeth, alveolplasty or gingivectomy performed in a hospital when the patient has an existing concurrent hazardous medical condition
  - Surgery on the jaw joint
  - Arthrocentesis performed for the reversible or irreversible treatment of jaw joint disorders

Technical surgical assistance

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

In some cases, an additional physician provides technical assistance to the surgeon. Certain procedures, when performed in a hospital inpatient or outpatient setting or in an ambulatory surgery facility, are identified as requiring technical surgical assistance.

We do not pay for technical surgical assistance:

- When services of interns, residents or other physicians employed by the hospital are available at the time of surgery, or
- When services are provided in a location other than a hospital or ambulatory surgery facility

Therapy services

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

Therapy services are paid if obtained in the outpatient department of a hospital, doctor's office, freestanding facility or by an independent physical therapist. Therapy must be medically necessary and ordered by, and performed under, the supervision or direction of a legally qualified physician except where noted.

Services are covered up to a **combined benefit maximum of 60 visits per member, per calendar year**, whether obtained from an in-network or out-of-network provider. All services provided in any outpatient location (hospital-based, freestanding facility or physician's office) are combined to meet the 60 visit maximum. (Therapy rendered in an inpatient hospital setting is not subject to the 60-visit maximum.)

The benefit maximum renews each calendar year. We recommend that a course of treatment plan be submitted to MESSA before treatment begins.

Outpatient benefits include the following:

Occupational therapy

Services must be performed by:

- A doctor of medicine or osteopathy
- An occupational therapist
- An occupational therapy assistant under the direct supervision of an occupational therapist
- An athletic trainer under the direct supervision of an occupational therapist

The occupational therapist and the occupational therapy assistant must be certified by the National Board of Occupational Therapy Certification and registered or licensed in the state where the care is provided.

Therapy services continued...

Physical therapy

Services must be performed by:

- A doctor of medicine, osteopathy or podiatry
- A licensed physical therapist
- A physical therapy assistant under the direct supervision of a licensed physical therapist
- An athletic trainer under the direct supervision of a licensed physical therapist

Therapy must be designed to improve or restore the patient's functional level when there has been a loss in musculoskeletal functioning due to an illness or injury.

Speech therapy

Services must be performed by:

- A doctor of medicine or osteopathy
- A licensed speech-language pathologist

We do not pay for services provided by speech-language pathology assistants or therapy aides.

For non-developmental conditions, treatment is available for both adults and children. For congenital and severe developmental conditions, treatment is available only for children.

Urgent care – see Emergency room

Vision therapy

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

Services must be performed by a qualified orthoptist to correct defective visual habits. Benefits are not provided for the following:

- Learning disabilities
- Reading problems including dyslexia
- Reading or educational enhancement
- Non-accommodative strabismus, such as muscle paralysis

Voluntary sterilization for men

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- Not covered
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org		

Reversal of sterilization procedures is not covered.

Voluntary sterilization for women

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- No cost to you	- Deductible - Coinsurance applies after deductible is met	- Not covered
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org		

Reversal of sterilization procedures is not covered.

Weight loss management – Preventive

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- No cost to you	- Not covered	- Not covered

One weight loss management visit per calendar year is payable without cost share for specific medical conditions.

Weight loss management – Medically necessary

What **You** Pay for Covered Services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating Provider**
- Deductible - Coinsurance may apply after deductible is met	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
For your plan's specific IN and OON benefit levels (deductible, coinsurance), log in to your member account at messa.org.		

We pay for services performed by a qualified physician for the treatment of morbid obesity. Call MESSA Member Services for more information. We do not cover weight loss treatment programs, such as Weight Watchers, Jenny Craig, or Medical Weight Loss Clinic.

Well baby/well child care – see Preventive services

Exclusions and limitations

The following exclusions and limitations apply to the MESSA Choices program. These are in addition to limitations appearing elsewhere in this booklet.

- Artificial insemination (including in vitro fertilization) and related services
- Treatment of work-related injuries covered by workers' compensation laws or for work-related services you receive through a medical clinic or a similar facility provided or maintained by your employer
- Charges toward your deductible, copayments or coinsurance requirements for in-network or out-of-network providers that:
  - exceed our approved amount
  - are for non-covered services and limited covered services (i.e. accidental injuries and medical emergencies), or
  - apply to deductibles, copayments or coinsurance paid under other certificates
- Charges incurred because of war, declared or undeclared, or any act thereof; or for injury or sickness sustained or contracted in the armed forces or any country, or for services provided in a Veterans Administration Hospital for a covered person with military service-connected disability; or for services, supplies or treatments provided or covered under any governmental plan or law or which would have been furnished without costs in the absence of this coverage or for which the covered person has no legal obligation to pay. However, care and services are payable if federal laws require the government sponsored program to be secondary.
- Clerical fees including fees for patient records, custodial care or basic care that can be provided by someone other than a registered nurse or licensed practical nurse, and which is care provided primarily to assist the person in the activities of daily living
- Dental care (except as previously specified) including repairs of supporting structures for partial or complete dentures, dental implants, extractions, extraction repairs, bite splints, braces and appliances and other dental work or treatment.
- Educational care and cognitive therapy
- Experimental treatment (including experimental drugs or devices) or services related to experimental treatment except as approved by the BCBSM or MESSA medical director. In addition, we do not pay for administrative costs related to experimental treatment or for research management.
- Eye examinations and eyeglasses or other corrective visual appliances except as specified elsewhere in this booklet
- Inpatient hospital confinement for the sole testing for, or detoxification of, allergy or allergy-related conditions
- Items for the personal comfort or convenience of the patient
- Reversal of sterilization procedures and related services
- Routine health examinations and related services or routine screening procedures (except as previously specified in the section on Preventive Care Services)

Exclusions and limitations continued...

- Services, supplies, or treatment provided by an immediate relative or by anyone who customarily lives in the member's household
- Services and supplies that are not medically necessary according to the accepted standards of medical practice including any services which are experimental or investigational in nature

Because of ongoing medical research and technological advances, procedures that have been considered experimental may become generally accepted standard treatments. To be covered under this plan, these procedures must be recognized as a standard of care and be medically necessary for the illness or injury being treated.

- Surgery for cosmetic or beautifying purposes, (except as specified in the section on cosmetic surgery)
- Transplants (other than those previously specified) and all charges arising out of, or associated with, these transplants whether incurred prior to the transplant or subsequent to the transplant
- Transportation expenses (except as previously specified) including meals and lodging
- Health care services provided by persons who are not legally qualified or licensed to provide such services
- Anti-rejection drugs that do not have Food and Drug Administration (FDA) approval
- Items that are not considered directly related to travel, meals and lodging in conjunction with the initial surgery and hospitalization for a human organ transplant (examples include but are not limited to the following: clothing, personal hygiene and related services, car maintenance, babysitters or daycare services and entertainment)
- Radiology procedures not directly related and necessary to diagnose the disease, illness, pregnancy or injury (such as ultrasound solely to determine the gender of the fetus)
- Self-administered, over-the-counter (OTC) drugs (these may be covered under your prescription drug program)
- Care and services for which you legally do not have to pay or for which you would not have been charged if you did not have coverage under this plan
- Speech and language pathology services to treat chronic conditions, congenital or inherited speech abnormalities, developmental conditions, or learning disabilities except for children
- Conditions such as Rett's Disorder and Childhood Disintegrative Disorder
- Any treatment that is not a covered benefit by us, including, but not limited to, sensory integration therapy and chelation therapy
- Medical or dental services performed for irreversible treatment of jaw joint disorders, except for:

  - Surgery on the jaw joint
  - Diagnostic X-rays
  - Arthrocentesis

*NOTE: The above restriction applies to **any** condition causing the jaw joint disorder*

- Prescription drugs

How to file a medical claim

Nonparticipating providers may require you to pay for services at the time they are provided. To file your own claim, follow these steps:

1. Ask the provider for an itemized statement with the following information:

- Patient's name and birth date
- Subscriber's name, address, phone number and contract number (from your ID card)
- Provider's name, address, phone number and federal tax ID number
- Date and description of services
- Diagnosis (nature of illness or injury) and procedure code
- Admission and discharge dates for hospitalization
- Charge for each service

2. Make a copy of all items for your files.

3. Mail the claim form and itemized statement to:

MESSA
1475 Kendale Blvd.
P.O. Box 2560
East Lansing, MI 48826-2560

Please file claims promptly because most services have a 24-month filing limitation.

If written authorization is attached to the itemized statement, MESSA will pay the provider; otherwise, payment will be sent to you. The check will be in the enrollee's name, not the patient's name.

NOTE: If you or your dependent(s) have coverage through another carrier who is primary (see "Coordination of Benefits" in this section), please send your bill to MESSA along with a copy of the other carrier's explanation of benefits.

MESSA will send you a benefit worksheet (explanation of benefits) when a claim is processed. Please keep these worksheets for future reference.

To find out if an out-of-area provider is a participating provider, please call 1.800.336.0013 or TTY 888.445.5614.

You may also visit the BlueCard Doctor and Hospital Finder website at www.bcbs.com for a listing of participating providers.

Care out of the country

We will only pay for services for emergency and unexpected illness for residents of the United States traveling in foreign countries. In addition, coverage applies only if:

- The hospital is accredited
- The physician is licensed

Most hospitals and doctors in foreign countries will ask you to pay the bill. Try to get itemized receipts, preferably written in English. When you submit your claim, tell us if the charges are in U.S. or foreign currency. Be sure to indicate whether payment should go to you or the provider. We will pay the approved amount for covered services at the rate of exchange in effect on the date you received your services, minus any deductibles, copayments or coinsurance that may apply.

Grievance process

We have a formal grievance and appeals process if you are unable to resolve your concerns through Member Services, or wish to contest an adverse benefit decision.

An adverse benefit determination is a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

If you choose to file a grievance or appeal:

- There is no cost to you to initiate a grievance or appeal. You may submit relevant written materials or written testimony to help us in our review at any step of the grievance or appeals process.
- You may authorize another person, including your physician, to act on your behalf at any stage in the standard internal grievance procedure. Your authorization needs to be in writing. Please call the customer service number on the back of your identification card and ask for a Designation of Authorized Representative and Release of Information form. Complete it and send it with your appeal.
- Although we have 35 days to give you our final determination, you have the right to allow us additional time if you wish.
- You may obtain copies of information relating to our denial, reduction or termination of coverage for a health care service free of charge.

The grievance and appeals process begins with an internal review by MESSA and BCBSM. Once you have exhausted your internal options, you have the right to a review by the Michigan Department of Insurance and Financial Services.

Standard internal grievance process

Step 1: You or your authorized representative must send us a written statement explaining why you disagree with our determination on your request for benefits or payment. Your request for review must be submitted within 180 days after receiving a notice of denial.

Mail your written grievance to:

Associate Manager, Legal and Compliance
MESSA
1475 Kendale Boulevard
P.O. Box 2560
East Lansing, MI 48826-2560

A decision will be made by MESSA/BCBSM after MESSA's receipt of request for review or the date all information required of you is furnished, whichever date is later. The decision will be in writing and will specify the reason for MESSA's/BCBSM's decisions.

Step 2: If you are dissatisfied with this decision, you may request a Managerial-level Conference by mailing your written request to the address in Step 1.

Grievance process continued...

Once we receive your grievance, we will contact you to conduct or schedule a conference. That will be your opportunity to provide us with any additional information or testimony you want us to consider in reviewing your claim. You can ask that the conference be conducted in person or over the telephone. If in person, the conference can be held at BCBSM headquarters in Detroit, during regular business hours. Our written resolution will be our final determination regarding your grievance.

BCBSM and MESSA will complete both steps within 35 days of the date we receive your written grievance under Step 1. This 35-day period does not include the time between your receiving our decision under Step 1 and requesting further review under Step 2.

If you disagree with our final determination, or if we fail to provide it to you within 35 days of the date we received your initial grievance under Step 1, you may request an external review from the Michigan Department of Insurance and Financial Services.

Standard external review process

Once you have exhausted our standard internal grievance process, you or your authorized representative may request an external review from the Michigan Department of Insurance and Financial Services.

The standard external review process is as follows:

1. Within 60 days of the date you received our final determination, or should have received it, send a written request for an external review to the Director. Mail your request, including the required forms that we will supply to you, to:

   Department of Insurance and Financial Services
   Office of General Counsel
   Health Care Appeals Section
   P.O. Box 30220
   Lansing, MI 48909-7720

2. If your request for external review concerns a medical issue and is otherwise found to be appropriate for external review, the Director will assign an independent review organization, consisting of independent clinical peer reviewers, to conduct the external review.

   – You will have an opportunity to provide additional information to the Director within seven days of submitting your request for an external review. We must provide documents and information considered in making our final determination to the independent review organization within seven business days after we receive notice of your request from the Director.

   – The assigned independent review organization will recommend within 14 days whether the Director should uphold or reverse our determination. The Director must decide within seven business days whether or not to accept the recommendation and will notify you. The Director's decision is the final administrative remedy under the Patient's Right to Independent Review Act of 2000.

If your request for external review is related to nonmedical issues and is otherwise found to be appropriate for external review, the Director's staff will conduct the external review.

The Director's staff will recommend whether the Director should uphold or reverse our determination. The Director will notify you of the decision, and the Director's decision is your final administrative remedy.

Grievance process continued...

Expedited internal grievance

If a physician substantiates (either orally or in writing) that adhering to the timeframe for the standard internal grievance process would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, you may file a request for an expedited internal grievance.

You may file a request for an expedited internal grievance only when you think that we have wrongfully denied, terminated or reduced coverage for a health care service prior to your having received that health care service, or if you believe we have failed to respond in a timely manner to a request for benefits or payment.

The procedure is as follows:

1. You may submit your expedited internal grievance request by telephone to 800.742.2328, option 4 or TTY 888.445.5614. The required physician's substantiation that your condition qualifies for an expedited grievance can also be submitted by telephone.
2. We must provide you with our decision within 72 hours of receiving both your grievance and the physician's substantiation.

If you do not agree with our decision, you may, within 10 days of receiving it, request an expedited external review from the Michigan Department of Insurance and Financial Services.

Expedited external grievance

If you have filed a request for an expedited internal grievance, you may request an expedited external review from the Michigan Department of Insurance and Financial Services.

You may file a request for an expedited external review only when you think that we have wrongfully denied, terminated or reduced coverage for a health care service prior to your having received that health care service.

The expedited external review process is as follows:

1. Within 10 days of your receipt of our denial, termination or reduction in coverage for a health care service, you or your authorized representative may request an expedited external review from the Director by calling 1.877.999.6442 to request the forms required.
2. Mail your request, including the required forms that we will give you, to:

Department of Insurance and Financial Services
Office of General Counsel
Health Care Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

Immediately after receiving your request, the Director will decide if it is appropriate for external review and assign an independent review organization to conduct the expedited external review. If the independent review organization decides that you do not have to first complete the expedited internal grievance procedure, it will review your request and recommend within 36 hours whether the Director should uphold or reverse our determination.

The Director must decide within 24 hours whether or not to accept the recommendation and will notify you. The Director's decision is the final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Grievance process continued...

PRE-SERVICE APPEALS

For members who must get approval before obtaining certain health services.

If your health plan requires you to get approval before obtaining certain health services, and you disagree with our decision not to approve a service, you have the right to appeal it.

Please follow the steps below to request a review. If you have questions or need help with the appeal process, please call the customer service number on the back of your identification card.

All appeals must be requested in writing. We must receive your written request within 180 days of the date you received notice that the service was not approved.

Requesting a standard review

You may make the request yourself, or your doctor or someone else acting on your behalf may make the request for you. If another person will represent you, that person must obtain written authorization to do so. Please call the customer service number on the back of your identification card and ask for a Designation of Authorized Representative and Release of Information form. Complete it and send it with your appeal.

Your letter requesting a review must include the following information:

- Your contract and group numbers, found on your identification card
- A daytime phone number for both you and your representative
- The patient's name if different from the member
- A statement explaining why you disagree with our decision and any additional supporting information

Once we receive your appeal, we will provide you with our final decision within 30 days.

Requesting an urgent review

If your situation meets the definition of urgent under the law, your review will be conducted as soon as possible; generally within 72 hours. An urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an urgent review. You may also request a simultaneous external review.

For more information on how to request an urgent review or simultaneous external review, call the customer service number listed on the back of your identification card.

For more information

At your request and without charge, we will send you details from your health care plan if our decision was based on your benefits. If our decision was based on medical guidelines, we will provide you with the appropriate protocols and treatment criteria. If we involved a medical expert in making this decision, we will provide that person's credentials.

To request information about your plan or the medical guidelines used, or if you need help with the appeal process, call the customer service number on the back of your identification card.

Other resources to help you

For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). You can also contact the Michigan Department of Insurance and Financial Services for assistance.

Other general information

This section lists and explains certain general conditions that apply to your contract. These conditions may make a difference in how, where and when benefits are available to you.

Contest

A person seeking payment from MESSA/BCBSM, directly or indirectly, will be furnished with the specific reason(s) for denial of a claim and an explanation of any additional information required from, or on behalf of, the member or dependent for reconsideration of the claim in accordance with our claim review procedure.

No action or suit at law may be commenced upon or under this plan until 30 days after notice has been given by the member and/or covered dependent to us that the reconsidered decision is unacceptable, nor may such action be brought at all later than two years after such claim has arisen.

Coordination of benefits

This plan requires Coordination of Benefits (COB). COB is used when you are eligible for payment under more than one group health, dental, vision or automobile no-fault insurance plan. This provision is to assure you that your covered expenses will be paid, but that the combined payments of all programs will exceed neither the amount of the actual cost, nor the amount that would have been paid in the absence of other coverage. Under COB, the plan that has the first obligation to pay is called the primary plan.

The guidelines used to determine the primary plan are:

- A group plan or automobile no-fault insurance plan with no provision for the coordination of benefits is always primary, otherwise,
- The plan sponsored by the employer of the person receiving the treatment is primary
- If the claim is for a dependent child covered under two or more plans, the primary plan is that of the parent whose birthday anniversary falls earlier in the year. If the birthdates are identical, the plan that has covered the dependent the longest is primary. However, benefits for a child of divorced or separated spouses are determined in the following order:
  - Plan of parent having financial responsibility as designated by court decree
  - Custodial parent's plan
  - Plan of the custodial parent's new spouse (if remarried)
  - Plan of noncustodial parent
- If the primary plan cannot be determined using the above guidelines, then the plan covering the person the longest is primary. The only exception to this rule is that if the coverage is through a member who is retired or laid off, and there is also coverage through a plan not involving a retired or laid off employee, the plan covering the person who is not a retired or laid off employee will be primary.

Other general information continued...

These COB provisions shall apply to any government or tax-supported program, unless other procedures are required by law. These provisions shall also apply to any benefits or services provided by group student health programs. Except for automobile no-fault insurance coverage, these COB provisions shall not apply to any non-group policy.

Determination of medical necessity

There may be instances when benefit restrictions may be waived for in-network services. When medically appropriate, personal care physicians and/or network managers may obtain authorization for covered services beyond our normal payment rules.

Subrogation

In certain cases, we may have paid for health care services for you or your covered dependents that should have been paid by another person, insurance company or organization. In these cases:

- You grant us a lien or right of reimbursement on any money or other valuable consideration you or your covered dependents or representatives receive through a judgment, settlement, or otherwise. You grant us the lien or right of reimbursement regardless of:

  1) Whether the money or other valuable consideration is designated as economic or noneconomic damages,

  2) Whether the recovery is partial or complete, and

  3) Who holds the money or other valuable consideration or where it is held.

- You agree to inform us when you hire an attorney to represent you, and to inform your attorney of our rights under this certificate.
- You must do whatever is necessary to help us recover the money we paid to treat the injury that caused you to claim damages for personal injury.
- You must not settle a personal injury claim without first obtaining our written consent if we paid for the treatment you received for that injury.
- You agree to cooperate with us in our efforts to recover money we paid on behalf of you or your dependents.
- You acknowledge and agree that this certificate supersedes any made whole doctrine, collateral source rule, common fund doctrine or other equitable distribution principles.

Release of information

Each person covered under this plan hereby authorizes physicians, hospitals and other providers of service to furnish to us, upon our request, information relating to services which the covered person is or may be entitled to under this plan. Physicians, hospitals and other providers of services are authorized to permit us to examine their records and to submit reports in the detail we request.

All information related to treatment of the covered person will remain confidential except for the purpose of determining rights and liabilities arising under this plan or when release is required by law.

Other general information continued...

Services before coverage begins or after coverage ends

Unless otherwise stated in this certificate, we will not pay for any services, treatment, care or supplies provided before your coverage under this certificate becomes effective or after your coverage ends. If your coverage begins or ends while you are an inpatient at a facility, our payment will be based on the facility's contract with BCBSM. Our payment may cover:

- The services, treatment, care or supplies you receive during the entire admission, **or**
- The services, treatment, care or supplies you receive while your coverage is in effect.

In addition, if you have other coverage when you are admitted to or discharged from a facility, your other carrier may be responsible for paying for the care you receive before the effective date of your MESSA coverage or after it ends.

Member liability

Certain technical enhancements, which may improve the safety or comfort of a procedure, may involve additional costs above and beyond the approved maximum payment level for the basic procedure. The costs of these enhancements are not covered. The provider must inform you of these costs. You then have the option of choosing any enhancements and assuming the liability for these additional charges.

Time limit for legal action

Legal action against us may not begin later than two years after we have received a complete claim for services. No action or lawsuit may be started until 30 days after you notify us that our decision under the claim review procedure is unacceptable.

What laws apply

This contract is subject to and interpreted under the laws of the state of Michigan.

Glossary of health care terms

Accidental injury

Any physical damage caused by an action, object or substance outside the body, such as:

- Strains, sprains, cuts and bruises
- Allergic reactions caused by an outside force such as bee stings or other insect bites
- Extreme frostbite, sunburn, sunstroke
- Swallowing poisons
- Drug overdosing
- Inhaling smoke, carbon monoxide or fumes

Accredited hospital

A facility that has been endorsed by one of the following organizations: Joint Commission on the Accreditation of Healthcare Organizations, the American Osteopathic Association or the Commission on Accreditation of Rehabilitation Facilities (see the definition of "Hospital").

Acute care

Medical care that requires a wide range of medical, surgical, obstetrical or pediatric treatment. It generally requires a hospital stay of less than 30 days.

Acute care facility

A facility that offers a wide range of medical, surgical, obstetric and pediatric services. These facilities primarily treat patients with conditions which require a hospital stay of less than 30 days. The facility is not used primarily for:

- Custodial, convalescent, tuberculosis or rest care
- Care of the aged or substance abusers
- Skilled nursing or other nursing care

Administrative costs (approved oncology trials)

Costs incurred by the organization sponsoring the approved oncology clinical trial. They may include, but are not limited to, the costs of gathering data, conducting statistical studies, meeting regulatory or contractual requirements, attending meetings or travel.

Allogeneic (Allogenic) bone marrow transplant

A procedure using another person's bone marrow or peripheral blood stem cells to transplant into the patient. This includes syngeneic transplants (when the donor is the identical twin of the patient).

Glossary of health care terms

Ambulatory surgery

Elective surgery that does not require use of extensive hospital facilities and support systems, but is not usually performed in a doctor's office.

Ambulatory surgery facility

A freestanding outpatient surgical facility offering surgery and related care that can be safely performed without the need for overnight inpatient hospital care. It does not include an office of a physician or other private practice office.

Ancillary services

Services other than room, board and nursing such as drugs, dressings, laboratory services and physical therapy.

Approved amount

The lower of the billed charge or our maximum payment level for the covered service. Deductibles, copayments and/or coinsurance, which may be required of you, are subtracted from the approved amount before we make our payment.

Approved clinical trial

A Phase I, II, III or IV clinical trial that is conducted for the prevention, detection or treatment of cancer or other life-threatening disease or condition, and includes any of the following:

- a federally funded trial, as described in the Patient Protection and Affordable Care Act (PPACA)

- a trial conducted under an investigational new drug application reviewed by the FDA

- a drug trial that is exempt from having an investigational new drug application

- a study or investigation conducted by a federal department that meets the requirements of Section 2709 of the PPACA

Attending physician

The physician in charge of a case and the one exercising overall responsibility for the patient's care:

- Within a facility (such as a hospital or other inpatient facility)
- As part of a treatment program
- In a clinic or private office setting

The attending physician may be responsible for coordination of care delivered by other physicians and/or ancillary staff.

Glossary of health care terms

Audiologist

A professional who is licensed or legally qualified in the state in which services are provided to perform audiometric and other procedures to assist in the diagnosis, treatment and management of individuals with hearing loss or balance problems.

Autism

- Autism diagnostic observation schedule

The protocol available through western psychological services for diagnosing and assessing autism spectrum disorders or any other standardized diagnostic measure for autism spectrum disorders that is approved by the commissioner of the Department of Insurance and Financial Regulation, if the commissioner determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

- Autism evaluation center

An academic and/or hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the Autism Spectrum Disorders. The autism evaluation center must be approved by BCBSM to:

- Evaluate and **diagnose** the member as having one of the covered autism spectrum disorders and
- Recommend an initial high-level treatment plan for members with autism spectrum disorders

- Autism spectrum disorders

This includes Autism Disorder, Autism Pervasive Developmental Disorder Not Otherwise Specified, or Asperger's Disorder, as defined in the most current American Psychiatric Association Diagnostic and Statistical Manual.

- Behavioral health treatment

Evidence-based counseling and treatment programs, including applied behavior analysis, that meet both the following requirements:

- Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual
- Are provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

- Line therapy

Tutoring or other activities performed one-on-one with a person diagnosed with an Autism Spectrum Disorder. Line therapy must be performed in accordance with a treatment plan that has been designed by a BCBSM-approved autism evaluation center and a board-certified behavior analyst.

Glossary of health care terms

Autism continued

- Board certified behavior analyst

An analyst certified by the Behavior Analyst Certification Board (BACB) at the time services are rendered.

NOTE: Board certified behavior analysts will be paid only for applied behavior analysis services. Any other treatment performed by board certified behavior analysts including, but not limited to, treatment of traumatic brain injuries will not be paid.

- Autism evaluation

An evaluation must include a review of the member's clinical history and examination of the member. Based on the member's needs, as determined by the BCBSM-approved treatment center, an evaluation may also include cognitive assessment, audiologic evaluation, a communication assessment, assessment by an occupational or physical therapist and lead screening.

- Autism prior authorization process

A process occurring before treatment is rendered in which a BCBSM nurse or case manager (or a BCBSM delegate/representative) approves all applied behavioral analysis services. A request for continued services will be authorized contingent on the member meeting mutually agreed upon (between BCBSM and the board certified behavior analyst) demonstration of measurable improvement and therapeutic progress, which can typically occur at 3, 6, or 9 month intervals or at other mutually agreed upon intervals after the onset of treatment.

- Autism treatment plan

A written, comprehensive, and individualized intervention plan that incorporates specific treatment goals and objectives and that is developed by a board certified or licensed provider who has the appropriate credentials and who is operating within his or her scope of practice, when the treatment of an autism spectrum disorder is first prescribed or ordered by a licensed physician or licensed psychologist.

Measurable improvement in the member's condition must be expected from the recommended treatment plan. Once treatment begins, the plan will be subject to periodic assessment by a BCBSM nurse or case manager at 3, 6 and/or 9 months or at mutually agreed upon intervals.

There are two levels to the treatment plan:

- The approved autism evaluation center will recommend an initial high-level treatment plan.
- The board certified behavior analyst will develop a detailed treatment plan specific to applied behavioral analysis treatment.

Glossary of health care terms

Autologous transplant

A procedure using the patient's own bone marrow or peripheral blood stem cells to transplant back into the patient.

BCBSM

Blue Cross Blue Shield of Michigan.

Blue Cross plan

Any nonprofit **hospital service plan** approved by the Blue Cross and Blue Shield Association at the time the hospital service is furnished.

Blue Shield plan

Any nonprofit **medical service plan** approved by the Blue Cross and Blue Shield Association at the time the medical service is furnished.

BlueCard PPO program

A program that allows MESSA/Blue Cross Blue Shield PPO members to receive health care services in other states and have claims processed by the Host Plan, subject to MESSA/Blue Cross and Blue Shield Association policies.

Certified nurse midwife

A nurse who provides some maternity services and who:

- Is licensed as a registered nurse by the state of Michigan
- Has a specialty certification as a nurse midwife by the Michigan Board of Nursing
- Has current national certification as a midwife by an organization recognized by the Michigan Board of Nursing
- Participates with BCBSM

Certified nurse practitioner

A nurse who provides some medical services and who:

- Is licensed as a registered nurse by the state of Michigan
- Has a specialty certification as a certified nurse practitioner by the Michigan Board of Nursing
- Meets our qualification standards

Glossary of health care terms

Certified registered nurse anesthetist

A nurse who provides anesthesiology services and who:

- Is licensed as a registered nurse by the state of Michigan
- Has a specialty certification as a certified registered nurse anesthetist by the Michigan Board of Nursing
- Meets our qualification standards
- When outside the state of Michigan, is legally qualified to perform anesthesiology services in the state where the services are performed.

Chronic condition

A disease or ailment that lasts a long time or recurs frequently. Heart disease and arthritis are examples of chronic diseases.

Claim for damages

A lawsuit against, or demand to, another person or organization for compensation for an injury to a person.

Clinical trial

A study conducted on a group of patients to determine the effect of a treatment. For purposes of this plan, clinical trials include:

- Phase II – a study conducted on a number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment.
- Phase III – a study conducted on a much larger group of patients to compare the results of a new treatment of a condition to the results of conventional treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

Coinsurance

A percentage amount that you must pay for a covered service after your deductible has been met.

Contraception

Birth control drugs, devices (such as but not limited to diaphragms, IUDs, and contraceptive implants) and injections designed to prevent pregnancy.

Contract

The insurance certificate and related riders, your signed application for coverage and your MESSA/BCBSM ID card.

Conventional treatment

Treatment that has been scientifically proven to be safe and effective for treatment of the patient's condition.

Glossary of health care terms

Copayment

The flat dollar amount that you must pay for a covered service.

Covered services

The services, treatments or supplies identified as payable in your certificate. Such services must be medically necessary, as defined in this booklet, and ordered or performed by a provider that is legally authorized or licensed to order or perform the service. The provider must also be appropriately credentialed or privileged, or eligible, as determined by us, to order or perform the service and must comply with our policies when rendering the service.

Custodial care

Care primarily used in helping the patient with activities of daily living or meeting personal needs. Such care includes help in walking, getting in and out of bed, bathing, dressing and taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training.

Deductible

The amount that you must pay for covered services before benefits are paid by us.

Dental care

Care given to diagnose, treat, restore, fill, remove or replace teeth, or the structures supporting the teeth, including changing the bite or position of the teeth.

Designated cancer center

A site approved by the National Cancer Institute as a cancer center, comprehensive cancer center, clinical cancer center or an affiliate of one of these centers. The names of the approved centers and their affiliates are available to you and your physician upon request.

Developmental condition

A condition that can delay or completely stop the normal progression of speech development. Speech therapy may not help these conditions.

Dialysis

Removal of toxic substance(s) from the blood.

Direct supervision

The type of supervision that requires the supervising personnel to be in the same physical structure where the service is being performed.

Glossary of health care terms

Durable medical equipment

Equipment that can withstand repeated use and that is used for a medical purpose by a patient who is ill or injured. It may be used in the home.

Effective date

The date your coverage begins under this contract. This date is established by us.

Emergency medical condition

A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) which could cause a prudent layperson with average knowledge of health and medicine to reasonably expect that the absence of immediate medical attention would result in:

- the health of the patient (or with respect to a pregnant woman, the health of the woman and her unborn child) to be in serious jeopardy, or

- serious impairment to bodily functions, or

- serious dysfunction of any bodily organ or part (or with respect to a pregnant woman who is having contractions, there is inadequate time for a safe transfer to another hospital before delivery or the transfer may pose a threat to the health and safety of the woman or the unborn child)

Emergency services

Emergency services include medical screening exams (as required under Section 1167 of the Social Security Act) that are within the capability of an emergency room department of a hospital, and include ancillary services routinely available in a hospital's emergency room to evaluate an emergency medical condition. They also include, within the capabilities of the staff and facilities available at the hospital, additional medical exams and treatment (as required under Section 1867 of the Social Security Act) to stabilize the patient.

End stage renal disease

Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

Exclusions

Situations, conditions, or services that are not covered by the subscriber's contract.

Experimental or investigational treatment

Treatment that has not been scientifically proven to be as safe and effective for treatment of the patient's condition as conventional treatment. Sometimes it is referred to as "experimental services."

Glossary of health care terms

Facility

A hospital or clinic that offers acute care or specialized treatment, such as substance abuse, rehabilitation treatment, skilled nursing care or physical therapy.

First degree relative

An immediate family member who is directly related to the patient; either a parent, sibling or child.

First priority security interest

The right to be paid before any other person from any money or other valuable consideration recovered by:

- Judgment or settlement of a legal action
- Settlement not due to legal action
- Undisputed payment

This right may be invoked without regard for:

- Whether plaintiff's recovery is partial or complete
- Who holds the recovery
- Where the recovery is held

Food and Drug Administration (FDA)

An agency with the U.S. Department of Health and Human Services that is responsible for protecting the public health by assuring the safety, efficacy and security of human drugs.

Freestanding outpatient physical therapy facility

An independently owned and operated facility, separate from a hospital, that provides outpatient physical therapy services and functional occupational therapy or speech and language pathology services.

Gynecological examination

A history and physical examination of the female genital tract.

Health maintenance examination

A comprehensive history and physical examination including blood pressure measurement, ocular tonometry (measurement of pressure in the eye), skin examination for malignancy, breast examination, testicular examination, rectal examination and health counseling regarding potential risk factors.

High-dose chemotherapy

A procedure in which patients are given cell-destroying drugs in doses higher than those used in conventional therapy. Stem cell replacement is required after high-dose chemotherapy is given.

Glossary of health care terms

High-risk patient

An individual who has an increased risk of mortality or morbidity according to standard criteria recognized by the oncology community.

HLA genetic markers

Specific chemical groupings that are part of many body cells, including white blood cells. Called human leukocyte antigens, these chemical groupings are inherited from each parent and are used to detect the constitutional similarity of one person to another. Close (or the degree of) identity is determined by tests using serologic (test tube) methods and/or molecular (DNA fingerprinting) techniques. An HLA identical match occurs when the six clinically important markers of the donor are identical to those of the patient.

Home health care agency

An organization that is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home.

Hospice

A public agency, private organization or subdivision of either, which primarily provides care for terminally ill persons.

Hospital

A facility that provides inpatient diagnostic and therapeutic services 24 hours every day for patients who are injured or acutely ill. The facility provides a professional staff of licensed physicians and nurses to supervise the care of the patients.

Host plan

A Blue Cross and/or Blue Shield Plan outside of Michigan that participates in the BlueCard PPO Program and processes claims for services that you receive in that state.

Independent physical therapist

A physical therapist that provides some physical therapy services and who:

- Is licensed as a physical therapist by the state of Michigan
- Meets our qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Glossary of health care terms

In-network providers

Physicians or other health care professionals who have contracted to provide services to members enrolled in MESSA Choices and to accept the approved amount as payment in full. Copayments, coinsurance and deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

Lien

A first priority security interest in any money or other valuable consideration recovered by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees we paid as a result of the plaintiff's injuries.

Lobar lung

Transplantation of a portion of a lung from a brain dead or living donor to a recipient.

Maternity care

Hospital and professional services for any condition due to pregnancy except ectopic (tubal) pregnancy.

Maxillofacial prosthesis

A custom-made replacement of a missing part of the face or mouth such as an artificial eye, ear, nose or an obturator to close a cleft. Excludes replacement of teeth or appliances to support teeth.

Medical emergency

A condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by an accidental injury.

Medically necessary

A service must be **medically necessary** to be covered. There are three definitions: one applies to professional providers (M.D.s, D.O.s, podiatrists, chiropractors, fully licensed psychologists and oral surgeons); another applies to hospitals and Long Term Acute Care Hospitals (LTACHs); and a third applies to other providers.

Medical necessity for payment of professional provider services:

Health care services that a professional provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's illness, injury or disease and

Glossary of health care terms

Medically necessary continued

- Not primarily for the convenience of the member, professional provider, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's illness, injury or disease.

NOTE: "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician or provider society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Determination by us that allows for the payment of covered hospital services when all of the following conditions are met:

Medical necessity for payment of hospital and LTACH services:

- The covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease.
- The service, treatment, or supply is appropriate for the symptoms and is consistent with the diagnosis. (Appropriate means that the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.)
- For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.
- The service is not mainly for the convenience of the member or health care provider.
- The treatment is not generally regarded as experimental by us.
- The treatment is not determined to be medically inappropriate by the Utilization Quality and Health Management Programs or by any other MESSA/BCBSM programs (applies only to hospitals, not to LTACHs).

Medical necessity for payment of services of other providers:

- Determination by physicians acting for us, based on criteria and guidelines developed by physicians for us who are acting for their respective provider type or medical specialty, that:

  The covered service is accepted as necessary and appropriate for the patient's condition. It is not mainly for the convenience of the member or physician.

  In the case of diagnostic testing, the results are essential to and are used in the diagnosis or management of the patient's condition.

NOTE: In the absence of established criteria, medical necessity will be determined by physicians according to accepted standards and practices.

Glossary of health care terms

Member

An individual who is a member of MESSA. For purposes of benefits under this plan, "member" includes you and your covered dependents.

MESSA

Michigan Education Special Services Association.

Nonparticipating hospital

A hospital that has not signed a participation agreement with BCBSM or another Blue Cross plan to accept the approved amount as payment in full.

Nonparticipating provider

Physicians or other health care professionals who have not signed a participation agreement with BCBSM to accept the approved amount as payment in full. Nonparticipating providers, however, may agree to accept the approved amount on a per claim basis.

Occupational therapy

A rehabilitative service that uses specific activities and methods. The therapist is responsible for involving the patient in specific therapeutic tasks and activities to:

- Develop, improve or restore the performance of necessary neuro-musculoskeletal functions affected by an illness or injury or following surgery
- Help the patient learn to apply the newly restored or improved function to meet the demands of daily living
- Design and use splints, ortheses (such as universal cuffs and braces) and adaptive devices (such as door openers, bath stools, large handle eating utensils, lap trays and raised toilet seats)

Off-label

The use of a drug or device for clinical indications other than those stated in the labeling approved by the federal Food and Drug Administration.

Orthopedic shoes

Prescribed by a physician or certified nurse practioner to support or correct the bones, joints, muscles, tendons and ligaments of a weak or deformed foot.

Orthotic device

An appliance worn outside the body to correct a body defect of form or function.

Glossary of health care terms

Out-of-area services

Services available to member living or traveling outside a health plan's service area.

Out-of-network provider

Hospitals, physicians and other licensed facilities or health care professionals who have not contracted to provide services to members enrolled in MESSA Choices.

Outpatient psychiatric facility

A licensed facility providing outpatient mental health services. It includes centers for mental health care such as hospitals, clinics, day treatment centers and community mental health centers as defined in the Federal Community Mental Health Centers Act of 1963, as amended.

Outpatient substance abuse treatment program

A program that provides medical and other services specifically for drug and alcohol abuse on an outpatient basis.

Partial liver

A portion of the liver taken from a brain dead or living donor.

Participating ambulatory surgery facility

A freestanding ambulatory surgery facility that has a signed participation agreement with BCBSM to accept the approved amount for covered services as full payment.

Participating hospital

A hospital that has signed a participation agreement with BCBSM to accept the approved amount as payment in full. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

Participating providers

Physicians or other health care professionals who have signed a participation agreement with BCBSM to accept the approved amount as payment in full. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

Patient

The subscriber or eligible dependent who is awaiting or receiving medical care and treatment.

Glossary of health care terms

Per claim participation

Available to nonparticipating providers when they elect to accept the approved amount for specific covered services as payment in full.

Peripheral blood stem cell transplant

A procedure where blood stem cells are obtained by pheresis and infused into the patient's circulation.

Pheresis

Removal of blood from the donor or patient in order to separate and retain specific components of the blood (red cells, white cells, platelets, stem cells).

Physical therapy

The use of specific activities or methods to treat a disability when there is a loss of neuromusculoskeletal functions due to an illness or injury, or following surgery. Treatments include exercise and therapy of the patient's specific muscles or joints to restore or improve:

- Muscle strength
- Joint motion
- Coordination
- General mobility

Physician

A physician is a doctor of medicine (M.D.) or osteopathy (D.O.) legally qualified and licensed to practice medicine and perform surgery at the time and place services are performed. An optometrist, oral surgeon dentist, podiatrist, doctor of chiropractic or other provider identified by us who is legally qualified and licensed to practice at the time and place services are performed is deemed to be a physician to the extent that the doctor renders services which he/she is legally qualified to perform.

A physician is also a person who is licensed under Act 368 Public Acts of Michigan 1978, as a fully licensed psychologist at the time services are performed. In a state where there are no certification or licensure requirements, a psychologist is one who is recognized as such by the appropriate professional society at the time and place services are performed.

Physicians may also be referred to as "practitioners."

Plaintiff

The person who brings the lawsuit or claim for damages. The plaintiff may be the injured party or a representative of the injured party.

Glossary of health care terms

Practitioner

A physician (a doctor of medicine, osteopathy, podiatry or chiropractic) or a professional provider (a doctor of medicine, osteopathy, podiatrist, chiropractor, fully licensed psychologist or oral surgeon) or other professional provider who participates with BCBSM or who is an in-network provider. Practitioner may also be referred to as "participating" or "panel" or "in-network" provider.

Preferred Provider Organization (PPO)

A limited group of health care providers who have agreed to provide services to MESSA members enrolled in this PPO program. These providers accept the approved amount as payment in full for covered services.

Primary payer

The health care coverage plan that pays first when you are provided benefits by more than one carrier.

Professional provider

This refers to one of the following:

- Doctor of medicine
- Doctor of osteopathy
- Podiatrist
- Chiropractor
- Fully licensed psychologist
- Oral surgeon
- Board certified behavior analyst
- Other providers as identified by us

Professional providers may also be referred to as "practitioners."

Prosthetic device

An artificial appliance that:

- Replaces all or part of a body part or
- Replaces all or part of the functions of a permanently disabled or poorly functioning body organ

Provider

A person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care.

Psychologist

A practitioner of clinical psychology, counseling or guidance, who is fully licensed and certified by the state of Michigan or by the state where you receive services. Where there are no certification or licensure requirements, the psychologist must be recognized by the appropriate professional society.

Glossary of health care terms

Purging

A process that attempts to remove abnormal cells from a blood or bone marrow sample so that a clean sample with only normal blood producing cells is obtained.

Qualified individual

An individual eligible for coverage who participates in an approved clinical trial according to the trial protocol for treatment of cancer or other life-threatening disease or condition and either:

- the referring provider participates in the trial and has concluded that the individual's participation in the trial would be appropriate because the individual meets the trial's protocol, or

- the individual provides medical and scientific information establishing that the individual's participation in the trial would be appropriate because he/she meets the trial's protocols.

Radiology services

These include X-ray exams, radium, radon, cobalt therapy, ultrasound testing, radioisotopes, computerized axial tomography scans and magnetic resonance imaging scans.

Referral

The process by which the member's physician directs a patient to a specialist for a specific service or treatment plan.

Refractory patient

An individual who does not achieve clinical disappearance of the disease after standard therapy.

Relapse

When a disease recurs after a period of time following therapy. This period of time is defined by evidence-based literature pertaining to the patient's condition.

Research management

Services, such as diagnostic tests, which are performed solely to support the sponsoring organization's research. They are not necessary for treating the patient's condition.

Residential substance abuse treatment program

A program that provides medical and other services specifically for substance abusers in a facility that operates 24 hours a day, seven days a week. Treatment in a program is sometimes called "intermediate care."

Respite care

Relief to family members or other persons caring for terminally ill persons at home.

Glossary of health care terms

Routine patient costs

All items and services related to an approved clinical trial if they are covered under this plan for members who are not participants in an approved clinical trial. They do not include:

- the investigational item, device or service itself

-items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient, or

- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

Screening services

Procedures or tests ordered for a patient (or for almost all patients of a particular class or group) that are not directly related to the diagnosis or treatment of a specific disease or injury. For example, tests routinely performed as part of a routine physical are considered screening.

Service area

The geographic area in which BCBSM is authorized to use the Blue Cross and Blue Shield name and service marks.

NOTE: BCBSM may contract with providers in areas contiguous with the state of Michigan. These providers' claims will not be subject to BlueCard rules.

Services

Surgery, care, treatment, supplies, devices, drugs or equipment given by a health care provider to diagnose or treat disease, injury, condition or pregnancy.

Skilled care

A level of care that can be given only by a licensed nurse to ensure the medical safety of the patient and the desired medical result. Such care must be:

- Ordered by the attending physician
- Medically necessary
- Provided by a registered nurse or a licensed practical nurse
- Supervised by a registered nurse or physician

Glossary of health care terms

Skilled nursing facilities

Facilities that provide continuous skilled nursing and other health care services by or under the supervision of a physician and a registered nurse.

Specialty hospitals

Hospitals that treat specific diseases, such as mental illness.

Specialty pharmaceuticals

Biotech drugs including high-cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. We determine which specific drugs are payable. This may include vaccines and chemotherapy drugs used in the treatment of cancer, but exclude injectable insulin. Select specialty pharmaceuticals require pre-authorization from us.

Specialty pharmacy

A company that specializes in specialty pharmaceuticals and the associated clinical management support.

Speech and language pathology services

Rehabilitative services that use specific activities or methods to treat speech, language or voice impairment due to an illness, injury or following surgery.

Stem cells

Primitive blood cells originating in the marrow, but also found in small quantities in the blood. These cells develop into mature blood elements including red cells, white cells and platelets.

Subrogation

Our assumption of your right, or the right of your dependents or representatives, to make a legal claim against or to receive money or other valuable consideration from another person, insurance company or organization.

Substance abuse

Taking alcohol or other drugs in amounts that can:

- Harm a person's physical, mental, social and economic well-being
- Cause a person to lose self-control as reflected by alterations of thought, mood, cognition, or behavior
- Endanger the safety or welfare of others because of the substance's habitual influence on the person

Substance abuse is alcohol or drug abuse or dependence as classified in the most current edition of the "International Classification of Diseases." *NOTE: Tobacco addictions are included in this definition.*

Glossary of health care terms

T-cell depleted infusion

A procedure in which T cells (immunocompetent lymphocytes) are eliminated from peripheral blood stem cells, bone marrow or umbilical cord blood.

Technical surgical assistance

Aid given in a hospital to the operating physician during surgery by another physician not in charge of the case.

NOTE: Professional active assistance requires direct physical contact with the patient.

Terminally ill

A state of illness causing a person's life expectancy to be 12 months or less according to a medically justified opinion.

Total body irradiation

A procedure that exposes most of the body to ionizing radiation to produce an anti-tumor effect that helps prevent rejection of a bone marrow, peripheral blood stem cell or umbilical cord blood transplant.

Urgent care

Walk-in care needed for an unexpected illness or injury that requires immediate treatment to prevent long-term harm. Urgent care centers are not the same as emergency rooms or doctors' offices.

Voluntary sterilization

Sterilization that is not medically necessary according to generally accepted standards of medical practice and is performed strictly at the request of the patient.

We, us, our

Used when referring to Blue Cross Blue Shield of Michigan or MESSA.

You and your

Used when referring to any person covered under the subscriber's contract.

Life and accidental death and dismemberment (AD&D) benefits

General provisions

The following will explain the life and AD&D benefits available to you under the MESSA Choices program. Life Insurance Company of North America (LINA) insures the life and dismemberment benefits. LINA will determine all benefit payments according to the provisions of the group policy.

Beneficiary

The beneficiary for your life and AD&D insurance for loss of life will be the person you name as shown in the records kept on the group insurance policy. If there is no named beneficiary living at your death, a lump sum will be paid to the first surviving class that follows;

- Spouse;
- Children;
- Parents;
- Brothers and sisters.

If none survives, the benefit will be paid to your estate in a lump sum.

If the beneficiary is a minor with no legal guardian, the minor's share may be paid to the adult (or adults) who, in LINA's opinion, has assumed custody and support of the minor. Payment may be made at a rate of up to $50 a month.

If you die after having applied to convert your group life insurance to an individual insurance policy, the beneficiary named in the individual policy (or in the application for it) will receive any benefits payable under the group insurance policy. You may change your beneficiary at any time. You do not need the consent of the beneficiary to make such change.

Life insurance benefits

As a MESSA member you have $5,000 of life insurance. Benefits are payable upon the member's death to the member's beneficiary in a single lump sum.

Assignment of life insurance

There is only one assignment of your life insurance that is valid. The assignment which:

- states that it is without consideration;
- is made to a named beneficiary;
- is in writing; and
- is accepted by LINA. The assignment may be made without the consent of the beneficiary.

Once an assignment is accepted and while it remains in force, the assignee can exercise any of the rights and privileges under the group policy granted to you (including but not limited to, the conversion privilege), and becomes entitled to receive all claim payments under the insurance assigned if no beneficiary is named by the assignee.

Acceptance of an assignment by LINA shall be without further liability as to any action or any payment or other settlement made by LINA before such acceptance.

While disabled

If you become totally disabled by injury or disease and you are not able to perform any work for pay or gain, your group life insurance coverage will continue for one year from the date the total disability is approved by LINA. You will continue to be covered for a benefit of $5,000.

Life and accidental death and dismemberment (AD&D) benefits continued...

To be eligible for this extended coverage, you must be under 65 years old when you become disabled, and you must remain totally disabled during the year-long period.

Note: If you remain disabled, your contributions will be waived and your coverage will continue.

Your contributions will be waived on the date that LINA receives satisfactory proof of your disability – but no earlier than six months after the onset of the disability. If you remain disabled after the first year of continued benefits, your coverage will continue without any contributions from you as long as you provide LINA with proof of the disability annually, within the three-month period prior to the anniversary of the date the total disability was approved.

If you do any work for pay or gain, you are no longer considered totally disabled.

If you converted to an individual life insurance policy while you were disabled, you must return the individual policy to LINA with your first proof of total disability. LINA will refund any contributions you made for the individual policy.

LINA maintains the right to have its medical representative examine you to verify the disability, but will not do so more than once a year after your extended coverage has continued for more than two years. There is no cost to you for medical exams requested by LINA.

If you die while disabled

If you die while you are still disabled, your beneficiary will receive the life insurance benefits as soon as proof of your continued disability is received by LINA.

If you die after you have converted your policy, any amount paid under the individual policy will be deducted from the amount due under the group life insurance policy and any contributions to the individual policy will be refunded to your beneficiary when the policy is returned.

When your extended coverage ends

Your extended coverage will end if you:

- cease to be totally disabled;
- fail to give required proof of your disability; or
- fail to submit to a medical exam.

After employment ends

You have 62 days to convert to an individual policy and pay your first contribution. You won't need to take a health exam, but you will be limited in your choice of policy. The individual policy amount must be no greater than $5,000, and you cannot convert to a policy that provides term insurance, universal or variable life insurance, benefits for disabilities, or extra benefits for accidental death.

If you have merely changed job classification, and are eligible for coverage under another group policy, the amount of your converted individual policy will be reduced by the amount of that group policy.

Life and accidental death and dismemberment (AD&D) benefits continued...

If your coverage ends because your employer terminated participation in the group policy or coverage for your job classification ends, you may convert to an individual policy if you have been insured by the group policy for at least five years in a row. The maximum amount of life insurance you may convert is the amount of coverage you had under the group policy, less the amount of any other group policy you became eligible for within 31 days after your coverage ended, up to a maximum of $2,000.

The individual policy will take effect 31 days after coverage under the group policy ends. Should you die in that period without converting, LINA will pay your beneficiary the amount you could have converted.

As an option to converting, you may continue your group life insurance on a direct payment basis by paying the required contribution for the cost of this insurance.

Contact MESSA Group Services for additional information.

Accidental death and dismemberment (AD&D) benefits

As a MESSA member you have $5,000 of AD&D insurance. If, while you are covered, you receive a bodily injury and experience a loss, LINA will pay you according to the schedule listed under "How AD&D Benefits are Paid."

In order to receive an AD&D benefit, the loss must:

- be caused exclusively by external and accidental means;
- be the direct result of the injury, independent of all other causes;
- occur within 180 days from the date of the injury.

All benefits other than loss of life will be paid to you. If you die, the benefits will be paid to your beneficiary.

How AD&D benefits are paid

For the loss of:	You receive:
Life	
Both hands or both feet	100% of AD&D
Sight in both eyes	benefit ($5,000)
Any two or more:	
one foot	
one hand	
sight in one eye	

For the loss of:	You receive:
One hand, or	50% of AD&D
One foot, or	benefit ($2,500)
Sight in one eye, or	
Speech, or Hearing	

For the loss of:	You receive:
Thumb & index finger of the same hand	25% of AD&D benefit ($1,250)

Life and accidental death and dismemberment (AD&D) benefits continued...

The following defines what is considered a loss:

Definition

Loss of one hand or foot

Loss by cutting off at or above the wrist or ankle joint

Loss of sight, speech, or hearing

Total loss that cannot be recovered

Loss of thumb & index finger

Loss by cutting off at the proximal phalangeal joint

When you suffer more than one loss

If you have more than one loss due to one accident, you will receive payment only for the loss with the largest benefit payout. You will only be paid for the loss resulting from the accident in question, regardless of any previous loss.

Losses not covered

No benefits will be paid for losses resulting from, or caused directly or indirectly by:

- bodily or mental infirmity;
- disease or illness of any kind;
- self-destruction or intentionally self-inflicted injury;
- taking part in an insurrection or riot, war or act of war, service in any military or naval organization, unless the injuries are sustained while off-duty;
- taking part in, or as a result of taking part in, a felony.

When coverage ends

AD&D coverage ends when your school employment ends or when you reach 65 years of age, whichever happens last. No assignment by you of your accidental death and dismemberment (AD&D) insurance is valid.

How to file a claim for life or AD&D benefits

Life claims

Contact MESSA Group Services for the forms necessary to file a life insurance claim.

AD&D claims

Contact MESSA Group Services for the forms necessary to file an AD&D claim. AD&D claims are subject to the following:

Filing Deadline – Written notice of the event upon which the claim is based must be given:

- within 20 days after the loss covered by the policy occurs or begins, or as soon after that time as is reasonably possible.

Notice – Notice must be given by, or on behalf of, the claimant to:

- LINA;
- MESSA; or
- any other authorized representative of LINA

The notice must include sufficient information to identify you.

Claim forms – On receipt of a notice of a claim, LINA or MESSA will give the claimant forms for filing proof of loss. If such forms have not been furnished within 15 days after the giving of the notice, the claimant can fulfill the terms of the policy as to proof of loss by giving written proof of:

- the occurrence of the loss
- the nature of the loss, and
- the extent of the loss

Proof of Loss – Written proof of the loss must be given to LINA within 90 days after:

- the date of the loss; or
- the end of the period for which LINA is liable.

Late proof will be accepted only if it is furnished as soon as is reasonably possible. In no event, except in the absence of your legal capacity, will proof be accepted later than one year from the time proof would otherwise have been required. Medical records may be required as proof of loss.

Time of Payment of Claims – Benefits are payable upon receipt of due proof of loss.

Payment of Claims – Benefits for loss of life will be paid in accordance with the beneficiary named by you, if any, and the terms of the policy in effect at the time payment is made.

Any part of the benefit for which there is no such beneficiary or terms in effect will be paid to your estate. Accidental dismemberment benefits will be payable to you.

If any benefit of the policy is payable to your estate, to you or your beneficiary while a minor, or to you or your beneficiary while not competent to give a valid release, LINA may pay such benefit, up to $1,000, to anyone related by blood or by marriage to you or the beneficiary, and deemed by LINA to be justly entitled. Any such payment made in good faith will discharge LINA to the extent of such payment.

How to file a claim for life or AD&D benefits continued...

Physical examination and autopsy – At its own expense, LINA has the right to have a doctor examine any person when it deems it reasonably necessary and there is a claim pending under the policy. LINA also has the right to make an autopsy in the case of death unless the law forbids it.

Legal actions – No one may sue for payment of a claim until 30 days after notice has been given to MESSA and LINA that the reconsidered decision is unacceptable. No one may bring suit more than three years after such claim has arisen.

Time limit on certain defenses – A claim will not be denied nor will the validity of coverage be contested because of any statement with respect to insurability made by you while eligible for coverage under the policy, if:

- the insurance has been in force for at least two years before any such contest; and
- the person with respect to whom any such statement was made was alive during those two years.

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