

MESSA ABC Plan 1

Medical plan highlights



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Effective Date: 1/1/2022

MESSA Account: Jenison Public Schools

Employee Group: 622D FT & PT Teachers & Health Prof

PAK C

In-network health care benefits for you and your covered dependents

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

This is a brief summary of in-network benefits. If you obtain medical services from an out-of-network provider without a referral from an in-network provider, you may have to pay 100 percent of the cost or the applicable out-of-network cost share amounts. For coverage details, go to messa.org to log in to your member account or call the MESSA Member Service Center at 800.336.0013 or TTY 888.445.5614.

Plan features	In-network
Annual deductible The amount you pay for health care services and prescription drug purchases before your health insurance begins to pay. The annual deductible is based on the calendar year, Jan. 1 to Dec. 31.	Single coverage: \$1,400 2-Person & Family coverage: \$2,800 <i>*Your deductible is subject to change each Jan. 1 according to IRS rules governing HSA-qualified plans.</i> <i>*When two or more lives are covered under this plan, the entire family deductible must be met before claims are paid for any individual.</i>
Medical coinsurance A fixed percentage you pay for a medical service.	10%
Prescription drug coverage Under federal law governing HSA-qualified plans, prescription drugs are subject to the deductible (other than MESSA's free preventive prescriptions). After deductible is met, applicable prescription copayments and/or coinsurance apply. See <i>Free preventive prescriptions below</i> .	ABC Rx with mandatory mail
Annual out-of-pocket maximums The most you have to pay for covered medical services and prescriptions in a calendar year, including deductible, copayments and coinsurance. Charges above approved amount and charges for services not covered under the plan do not count toward the out-of-pocket maximum.	Single coverage: \$3,400 2-Person & Family coverage: \$6,800
In-network services covered at no cost to you	
Free preventive prescriptions MESSA ABC covers an extensive list of FREE preventive prescriptions that have no deductible, copayment or coinsurance, including cholesterol and blood pressure medications, weight loss medications, prenatal vitamins, contraceptives and many more.	
Preventive care and prenatal care Certain services such as annual exams, screenings, childhood and adult immunizations, certain preventive medications and prenatal doctor visits.	

In-network services subject to deductible and applicable coinsurance

Blue Cross online visit	Urgent care
Office visit	Hospital emergency room (ER)
Chiropractic services including modalities Up to 38 visits per calendar year.	Osteopathic manipulations Performed by an Osteopathic physician. Up to 38 visits per calendar year.
Inpatient hospital	Autism - applied behavior analysis (ABA) services
Outpatient physical, occupational and speech therapy Up to a combined benefit maximum of 60 visits per individual per calendar year.	Hearing aids 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.
Hearing care Hearing related services performed by an M.D. or D.O.	Acupuncture Must be performed by an M.D. or D.O.
Diagnostic lab and X-ray	Radiation and chemotherapy
Allergy testing and therapy	Bariatric surgery
Mental health and substance abuse - inpatient and outpatient care	Ambulance
Medical supplies	Durable medical equipment (DME)
Prosthetics and orthotics	Home health care
Skilled nursing facility Up to a maximum of 120 days per calendar year.	Human organ transplant Must be performed at an approved facility.

Home delivery of prescription medications

MESSA members can save time and money by ordering prescription medications through the Express Scripts mail order pharmacy. If your coverage includes a mandatory mail prescription rider, you must obtain most long-term maintenance medications from Express Scripts. For more information, go to messa.org to log in to your member account and link to the Express Scripts website. For general questions about your prescription coverage, call MESSA at 800.336.0013 or TTY 888.445.5614. For questions about a prescription order, call Express Scripts at 800.903.8346

Medical care outside the U.S.

MESSA members have access to doctors and hospitals with the BCBS Global Core program. You may want to visit the BCBS Global Core program's website (www.bcbsglobalcore.com) to find in-network providers prior to your departure.

Covered services and approved amounts

In-network providers bill BCBSM directly. Payments for covered services are based on BCBSM's approved amounts. Your liability is limited to the plan deductible, copayment and coinsurance requirements.

Out-of-network providers may or may not bill BCBSM directly. The member is responsible to the provider for any deductibles, copayments, coinsurance and amounts that are in excess of the approved amount for the services as predetermined by MESSA and BCBSM. These amounts may be substantial.

Medical benefits underwritten by Blue Cross Blue Shield of Michigan (BCBSM) & 4 Ever Life Insurance Company. BCBSM is an independent licensee of the Blue Cross and Blue Shield Association.

Life and accidental death & dismemberment insurance

Life insurance: \$5,000 policy for you.

Accidental death & dismemberment insurance (AD&D): \$5,000 policy for you.

AD&D terminates at age 65 or when employment ends, whichever comes later.

Life and AD&D insurance underwritten by Life Insurance Company of North America.



MESSA ABC & ABC Rx

Plan 1 Coins 10% w/Mandatory Mail



Coverage for: Individual/Family | Plan Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.messa.org or call MESSA at 1-800-336-0013. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call MESSA at 1-800-336-0013 to request a copy.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall <u>deductible</u> ?	\$1,400 Individual/ \$2,800 Family	\$2,800 Individual/ \$5,600 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at (https://www.healthcare.gov/coverage/preventive-care-benefits/).
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)	\$3,400 Individual/ \$6,800 Family	\$6,800 Individual/ \$13,600 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, <u>deductible</u> , any <u>pharmacy</u> penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. For a list of <u>network providers</u> see (http://www.messa.org) or call MESSA at 800-336-0013		This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a specialist?	No.		You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Specialist visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Preventive care</u> /screening/immunization	No Charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	May require <u>preauthorization</u>
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.messa.org	Generic or prescribed over-the-counter drugs	\$10 <u>copay</u> /prescription for retail 34-day supply; \$20 <u>copay</u> /prescription for mail order 90 day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	Preventive drugs covered in full. A 90-day supply of prescription drugs is not payable at a retail pharmacy. A 90-day supply is only payable at a participating mail order pharmacy. Mail order drugs are not covered out-of-network.
	Preferred brand-name drugs	\$40 <u>copay</u> /prescription for retail 34-day supply; \$80 <u>copay</u> /prescription for mail order 90 day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	
	Non-preferred brand-name drugs	\$40 <u>copay</u> /prescription for retail 34-day supply; \$80 <u>copay</u> /prescription for mail order 90 day supply	In-Network <u>copay</u> plus an additional 25% of the approved amount	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Emergency room care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Mileage limits apply
	<u>Urgent care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required
	Physician/surgeon fee	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services <u>cost share</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Home health care	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Physician certification required.
If you need help recovering or have other special health needs	Rehabilitation services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to <u>preauthorization</u> .
	Skilled nursing care	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Physician certification required. Limited to 120 days per member per calendar year
	Durable medical equipment	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Physician certification required. Unlimited visits.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
For more information on pediatric vision or dental, contact your plan administrator	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|-----------------------|----------------------------|------------------------|
| • Cosmetic Surgery | • Long term care | • Routine foot care |
| • Dental care (Adult) | • Routine eye care (Adult) | • Weight loss programs |

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

- | | | |
|-------------------------|---|---|
| • Acupuncture treatment | • Coverage provided outside the United States.
See (http://www.messa.org) | • Non-emergency care when traveling outside the U.S |
| • Bariatric surgery | • Hearing aids | • Private-duty nursing |
| • Chiropractic care | • Infertility treatment | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling 1-800-324-6172. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a claim. This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact MESSA by calling 1-800-336-0013.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or <http://www.michigan.gov/difs> or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#). (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your [plan](#) may be affected if your [plan](#) does not cover certain EHB categories, such as [prescription drugs](#), or if your [plan](#) provides coverage of specific EHB categories, for example [prescription drugs](#), through another carrier.)

Language Access Services: See Addendum

_____To see examples of how this plan might cover costs for a sample medical situation, see the next section.



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,400
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This **EXAMPLE** event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,400
Copayments	\$10
Coinsurance	\$900
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,370

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

- The plan's overall deductible \$1,400
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This **EXAMPLE** event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,400
Copayments	\$600
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,120

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

- The plan's overall deductible \$1,400
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This **EXAMPLE** event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,400
Copayments	\$10
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,510

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or coinsurance, or benefits not otherwise covered.

Language services

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call MESA's Member Service Center at 800.336.0013 or TTY 888.445.5614.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de servicios para miembros de MESSA, que aparece en la parte trasera de su tarjeta.

إنما كنت أنت أو شخص آخر تساعد بحاجة إلى المساعدة، فمن حذك الحصول على المساعدة والمعلومات بيفتك بدون أي كلفة للإحداث إلى مركزهم، اتصل بالرقم المخصص

如果您，或是您正在協助的對象，需要協助，您有權利免費已您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的延SSA會員服務電話。

Nếu quý vị hoặc ai đó mà quý vị đang giúp đỡ, cần sự giúp đỡ, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, hãy gọi đến số dịch vụ thành viên MESSA trên mặt sau của thẻ.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj, për të folur me një përkthyes, telefononi numrin e shërbimit të anëtarësimit MESSA në anën e pasme të kartës tuaj.

귀하 또는 귀하의 도음을 제공하는 부근가가 도음이
필요한 경우, 귀하의 도음과 귀하의 도음을 받기 위해
동역사의 도음을 받으면 카드 뒷면의 MESSA 회원
서비스 포털로 전환하십시오.

[illegible]

যদি আপনার বা আপন সাহায্য করেন এমন কারো সম্মতের প্রয়োজন হয়, তাহলে করানা খরচ ছাড়াই আপনার ভাষা সহায়তা ও তথ্য পাওয়ার অধিকার রয়েছে। করানা অভিযন্ত্র সারণী ক্যা ব্রেত, আপনার কার্ডের কপছরন প্রিন্ট MESSA সিস্য পদারবণার নম্বর কে করুন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi członków MESSA wskazany na odwrocie Twojej karty.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigen, haben Sie das Recht kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer der MESSA-Mitgliedsbetreuung auf der Rückseite Ihrer Karte an. Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere gratuitamente aiuto e informazioni nella tua lingua. Per parlare con un interprete, chiama il numero del servizio membri MESSA presente sul retro della tua tessera.

ご本人様、またはお客様の方で支拂を必要とされる方で質問がございましたら、ご希望の言語でサポートを受けたり、情報入手したりすることが出来ます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたMESSAメンバーサービスの電話番号までお電話ください。

Если Вам или лицу, которому Вы помогаете, нужна помощь, то Вы имеете право на бесплатное получение помощи и информации на Вашем языке. Для разговора с переводчиком позвоните по номеру

телефона MESSA отдела обслуживания клиентов, указанному на обратной стороне Вашей карты. Условно же вам или некоем кому можете потребна помощь, имате право добити помоћ! Информацију на вашем језику бесплатно. Да бисте разговарали са преводиоцем, позовите број за услуге чланова MESSA на задњој страни ваших картица.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makuha ang isang interpreter, tumawag sa numero para sa mga serbisyo sa miyembro ng MESSA na nasa likuran ng iyong card.

Important disclosure

MESSA and Blue Cross Blue Shield of Michigan (BCBSM) comply with federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. MESSA and BCBSM provide free auxiliary aids and services to people with disabilities to communicate effectively with us, including qualified sign language interpreters. If you need assistance, call MESSA's Member Service Center at 800.336.0013 or TTY 888.445.5614.

If you need help filing a grievance, MESSA's general counsel is available to help you. If you believe that MESSA or BCBSM failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, or by mail, phone, fax or email: General Counsel, MESSA, P.O. Box 2560, East Lansing, MI 48826-2560, 800.292.4910, TTY: 888.445.5613, fax: 517.203.2909 or [CivilRights-GeneralCounsel@messa.org](mailto:GeneralCounsel@messa.org).

You can also file a civil rights complaint with the Office for Civil Rights on the web at OCRComplaint@hhs.gov, or by mail, phone or email: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, 800.368.1019, TTD: 800.537.7697, or OCRComplaint@hhs.gov.