essentials®
by messa

Medical plan coverage

800-336-0013 • TTY: 888-445-5614

Table of Contents

If you are reading the online version of this booklet, you can click on any topic in this table of contents to review that information.

Helpful information 5
How to contact us 5
Tips to help us serve you better 5
Your MESSA card 6
Explanation of Benefit (EOB) statements 6
Eligibility guidelines 7
Who is eligible for coverage? *7*
Applying for coverage *7*
Eligible dependents *7*
When coverage begins *8*
When coverage ends *8*
Continuation of healthcare coverage 9
Individual coverage 9
Surviving family 10
PPO coverage 10
In-network providers *10*
Out-of-network providers *10*
Mandatory Prior Authorization 11
What happens if your PPO physician leaves the network 11
What you should know about referrals 11
Pre-Admission Review requirements 12
You have access to personal support from a MESSA nurse 12
Medical care while traveling in the U.S. 13
Medical care while traveling outside the U.S. 13
Deductibles 14
Copayments 14
Coinsurance 14
Annual out-of-pocket maximum 14
Cost share for behavioral health 14
Alphabetical listing of specific covered services 15
Allergy services *15*
Ambulance *15*
Anesthesia *16*
Autism Spectrum Disorders *16*
Behavioral Health Services (Mental Health and Substance Use Disorder) *17*
Bone marrow transplants *20*

Table of Contents

Cellular and gene therapy 22
Certified nurse midwife services – see Maternity care 22
Chemotherapy 23
Chiropractic services – see Spinal manipulations 23
Colonoscopy – Medically necessary 23
Colonoscopy – Preventive 24
Consultations 24
Cosmetic surgery – Medically necessary 24
Dental surgery 25
Diabetic supplies 25
Diagnostic services 26
Diagnostic laboratory and pathology services 26
Durable Medical Equipment (DME) 27
Emergency room (ER) – Facility charges 27
Emergency room (ER) – Physician charges 28
End Stage Renal Disease (ESRD) 28
Fertility preservation 29
Gender affirming services 29
Hearing care services – M.D. or D.O. 30
Hearing care services – Audiologist 30
Hemodialysis 30
Home healthcare 31
Hospice care 31
Hospital care 32
Human organ transplants 33
Human organ transplants (cornea and skin) 35
Mammography – Medically necessary 35
Mammography – Preventive 35
Maternity care – Delivery, ultrasounds and certain labs 36
Maternity care – Prenatal and postnatal preventive care 36
Medical Case Management (MCM) claims 37
Medical supplies 37
Nutritional counseling – Preventive 38
Obstetrics – see Maternity care 38
Occupational therapy – see Therapy services 38
Office, outpatient, and home physician visits 38
Oncology clinical trials 38
Osteopathic manipulations – see Spinal manipulations 40
Physical therapy – see Therapy services 40
Prescription drugs 40

Table of Contents

Preventive care services *40*
Private duty nursing *41*
Prosthetic and orthotic devices *41*
Radiology services *42*
Skilled nursing care – Facility charges *43*
Speech therapy – see Therapy services *43*
Spinal manipulations *44*
Surgical services *44*
Technical surgical assistance *45*
Telehealth *45*
Telehealth – Teladoc Health *45*
Telehealth – Teladoc Virtual Primary Care *46*
Telehealth – Telemedicine *46*
Therapy services *47*
Urgent care *48*
Vision therapy *48*
Voluntary sterilization for men *48*
Voluntary sterilization for women *49*
Well baby/well child care – see Preventive services *49*
Exclusions and limitations **50**
How to file a medical claim **51**
Grievance process **52**
Other general information **56**
Glossary **61**
Language Services **75**

Helpful information

Healthcare benefits provided under the Essentials by MESSA 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 **messa.org** to access your MyMESSA 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 MESSA member service representative 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 **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.

Tips to help us serve you better

Here are some important tips to remember:

- Have your MESSA card handy so you can provide your subscriber ID/contract number. If you are writing to us, include this information in your correspondence.
- 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.

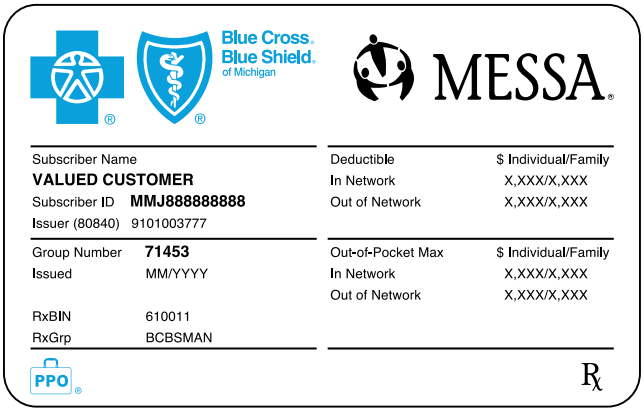
  NOTE: Benefits cannot be guaranteed over the phone.
- To inquire about a claim, please provide the following:
  - » Patient's name
  - » Provider's name (such as the doctor, hospital or supplier)
  - » Date the patient was treated
  - » Type of service (for example, an office visit)
  - » Charge for the service
- 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.
- Include your daytime telephone number as well as your subscriber ID/contract number on all correspondence.

How to contact us

Give us a call	Online chat	By mail
MESSA Member Service Center 800-336-0013 or TTY: 888-445-5614	Log in to your **MyMESSA member portal** to connect with a member service specialist via member chat and secure message.	MESSA 1475 Kendale Blvd., P.O. Box 2560 East Lansing, MI 48826-2560

Your MESSA card

Your MESSA identification card is your key to receiving quality healthcare. Your card will look similar to the one shown.



- **Subscriber name** is the name of the person who holds the contract.
- **Subscriber ID** identifies your records in our files.
- The **alpha prefix** preceding the subscriber 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 MESSA card, you will find MESSA's toll-free number for our Member Service Center, which you can call when you have a claim or benefit inquiry, as well as other important telephone numbers.

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

Here are some tips about your MESSA 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 a MESSA card, you can:
  - » Register for, or log in to, your MyMESSA account at **messa.org** to request a card (two will be sent per request).
  - » Log in to your MyMESSA 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 Subscriber 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 statement each time we process a claim under your subscriber 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 (subscriber ID)
- Claim number
- Date of service
- Type of service
- Amount billed by the provider
- Payments from other insurance
- Approved amount for MESSA payment
- Participating provider savings
- Amount paid by MESSA
- Deductible amount applied to this claim
- Copayments or coinsurance amounts applied to this claim

- Remark code(s) explaining variance
- Summary of annual deductible

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

Go paperless! Log in to your MyMESSA 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 MESSA card illegally, contact the anti-fraud toll-free hotline at 866-211-4475. Your call will be kept strictly confidential. By working together, we can help keep healthcare 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 member of the Michigan Education Association (MEA) as defined by the MEA bylaws
- Any individual employed by an educational agency that has negotiated MESSA benefits for its members
- Any employee of the State of Michigan or any political subdivision of the State, including but not limited to, counties, townships, cities, villages, school districts, and any authorities created by political subdivisions
- 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 employers
- Covering dependent children age 26 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 (this does not include the person who marries a member who has coverage as a surviving spouse).
- Your children. Children are covered through the end of the month or calendar year in which they turn 26 years of age, based on employer guidelines and subject to the following conditions:
  - » You continue to be covered under this plan.
  - » The children are related to you by birth, marriage, legal adoption or legal guardianship.

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

  - » Disabled, unmarried children beyond the end of the calendar year in which they turn age 26 if all of the following apply:
    - — They are diagnosed as totally and permanently disabled due to a physical or developmental disability.
    - — They are dependent on you for support and maintenance.
    - — They are incapable of self-sustaining employment by reason of their disabilities. (Under no circumstances will mental illness be considered a cause of incapacity. Neither will it be considered as a basis for continued coverage.)
    - — Please contact MESSA to obtain the appropriate form to continue coverage. Included with those forms will be a required physician's certification.
  - » Your unmarried children beyond the end of the calendar year of their 26th birthday (if covered under this plan and 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 must obtain written certification from his or her attending physician. The certification must verify that the student suffers from a serious illness or injury. It must further state that the leave or change in status is medically necessary. The student must continue to meet all other MESSA eligibility requirements.

- Sponsored dependents who are members of your family, either by blood or marriage. They must qualify as your dependents under the Internal Revenue Code and be declared as dependents on your federal tax return for the preceding tax year. They must be 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 become 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

During your active employment, special healthcare coverage guidelines apply to you and your spouse when you reach age 65. You should contact your employer or MESSA for complete details. You should contact the Social Security Administration about Medicare enrollment 120 days before you turn 65.

When coverage begins

- If you are a new employee and enroll for coverage within 30 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 they become an eligible dependent if enrolled within 30 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 they become an eligible dependent.

When coverage ends

Your Essentials by MESSA 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 the 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 MESSA or another party that 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 MESSA for payment of 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.
- **Termination of the MESSA/BCBSM group agreement** – Coverage will end on the date the group agreement terminates.
- **Member turns 65** – Coverage will end on the first day of the calendar month in which a covered member becomes age 65, unless the covered member continues active employment.
- **Medicare elected as primary** – If you continue active employment beyond age 65 and elect Medicare as your primary coverage, your coverage under Essentials by MESSA 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 their primary coverage; the spouse's coverage under Essentials by MESSA will end on the first day of the month following such an election.

*NOTE: If you cease active work, inquire as to what arrangements, if any, may be made to continue coverage. Also see the following "**Continuation of healthcare coverage**." Contact MESSA for additional information.*

Continuation of healthcare coverage

COBRA (Consolidated Omnibus Budget Reconciliation Act)

COBRA is a federal law that allows you to continue your employer group coverage if you lose it due to a qualifying event. The continued coverage is available to you, your spouse and your dependent children (all of whom are referred to as "qualified beneficiaries"). Your employer must send you a COBRA notice. You have 60 days to choose to continue your coverage. The deadline is 60 days after you lose coverage or 60 days after your employer sends you the notice, whichever is later. If you choose to keep group coverage you must pay for it. The periods of time you may keep it for are:

- 18 months of coverage for an employee who is terminated, other than for gross misconduct, or whose hours are reduced.
- 29 months of coverage for all qualified beneficiaries if one member is determined by the Social Security Administration to be disabled at the time of the qualifying event or within 60 days thereafter.
- 36 months of coverage for qualified beneficiaries in case of the death of the employee, divorce, legal separation, loss of dependency status or employee entitlement to Medicare.

COBRA coverage can be terminated because:

- The 18, 29 or 36 months of COBRA coverage end
- The required premium is not paid on time
- The employer terminates its group health plan
- The qualified beneficiary becomes entitled to Medicare coverage
- The qualified beneficiary obtains coverage under a group health plan

Please contact your employer for more details about COBRA.

Individual coverage

When you are no longer eligible for the Essentials by MESSA plan through your employer, an individual healthcare plan is available to you through BCBSM. Your benefits under the individual plan may differ from the benefits covered under the Essentials by MESSA plan and coverage will be limited to your immediate family.

If you select COBRA coverage when your coverage under this plan ends, you must exhaust it first to be eligible for individual coverage.

Contact MESSA for additional information on how to apply for this coverage.

Surviving family

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

PPO coverage

Essentials by MESSA has different levels of benefits for in-network and out-of-network providers because it uses a Preferred Provider Organization (PPO) network. This means that what you pay depends on the type of provider you choose. Providers are classified as follows:

- **In-network** – providers who have agreed to accept BCBSM's approved amount as payment in full for covered services (after deductible, copayments and coinsurance where applicable)
- **Out-of-network** – providers who have not contracted with BCBSM to provide services to members enrolled in the PPO program
  - » **Participating** – providers who have signed a participation agreement with BCBSM to accept the approved amount as payment in full (after deductible, copayments and coinsurance where applicable)
  - » **Nonparticipating** – providers who have not contracted with BCBSM and have not signed a participation agreement with BCBSM

In-network providers

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

More than 80% 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 your group save on its premiums.

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

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

To find an in-network provider:

- Ask your doctor or other medical provider if they are in our network.
- Go to **messa.org** to use our "Find Care" feature.
- 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 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.

There are two types of out-of-network providers:

- **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 has signed a participation agreement with BCBSM.

  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 BCBSM's approved amount and their charges.

Note: Most 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 have not signed a participation agreement with BCBSM. 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 BCBSM 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 for covered services, less the out-of-network deductible and coinsurance.

Mandatory Prior Authorization

Some admissions and services require prior authorization from MESSA/BCBSM before we will pay for them. These prior authorization requests must be submitted by your provider electronically, pursuant to Michigan law. If prior authorization is not requested or received, MESSA/BCBSM will not pay for the service. You will be responsible for 100% of the cost of the service. For some services, certain clinical criteria must be met before coverage is provided.

Once we receive the provider's request for prior authorization, we will notify the provider whether a service is authorized, not authorized, or if the request requires additional information within:

- 7 days
- 72 hours, if your request is urgent

NOTE: If we approve the request, we will pay the approved amount minus your coinsurance or copayment.

Instructions for providers to submit electronic prior authorization requests and a list of services that require mandatory prior authorization are available at **messa.org/PriorAuthorization**.

What happens if your PPO physician leaves the network

Your physician is your partner in managing your healthcare. However, physicians retire, move or otherwise cease to be affiliated with the BCBSM. If this happens, your physician should notify you that they are 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 member service representative will explain the financial costs to you when services are performed by a physician who is no longer in the PPO network.

Providers may choose to terminate their participation contract with BCBSM. If a provider terminates its participation, services will be covered in limited circumstances. For more information on these benefits, see the temporary benefits section.

What you should know about referrals

Want to visit an out-of-network provider? Start with a referral.
Your in-network PPO provider should refer you to another in-network PPO provider when available. If one is not available, your provider should refer you to a participating provider. This is a provider who accepts BCBSM, but is not in the PPO network. 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 in-network deductible, copays and coinsurance apply. Referrals are good for one year. You may still be responsible for charges over the approved 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.

Pre-Admission Review requirements

In-network and participating facilities

The hospital will take care of this requirement for you.

Out-of-network, nonparticipating facilities

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

Your doctor or hospital must electronically submit a prior authorization request through the MESSA provider portal found at **messa.org/PriorAuthorization**. Providers may also call the toll-free MESSA hospital admissions line at 800-336-0022 or TTY: 888-445-5614 for assistance. 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 the 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.

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

MESSA's Medical Case Management (MCM) program provides members with serious illnesses or injuries with personal support from a registered nurse.

MESSA's MCM nurses work directly with members and their families to ensure they access the right care at the right time and return to their highest quality of life.

The nurses work with members who have had a variety of catastrophic injuries or illnesses, including head injuries, spinal cord injuries, amputations, severe burns, multiple fractures, cancer, ALS, multiple sclerosis, stroke, muscular dystrophy and infants with complex medical issues.

Through the MCM program, MESSA's nurses can assist you in navigating the healthcare system, identifying local resources, and serving as your personal advocate during a difficult and often stressful time.

For more information, call 800-441-4626 or visit **messa.org/mcm**.

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, copayment and coinsurance.

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 card with you.

Prior authorization is required if you or a covered dependent requires hospitalization. Providers can electronically submit a prior authorization request through the MESSA provider portal found at **messa.org/PriorAuthorization**, or call the toll-free MESSA hospital admissions line 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 card with you. Call 800-336-0013 or TTY: 888-445-5614 or visit **messa.org** to find a doctor or hospital.

For non-emergency care:

Find an in-network doctor at **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 will likely increase and likely won't be covered for all services.

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

Medical care while traveling outside the U.S.

You have access to doctors and hospitals with Blue Cross Blue Shield Global Core. You may want to visit the Blue Cross Blue Shield Global Core program's website (**BCBSGlobalCore.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 card. Emergency and urgent care are covered no matter where you are. If you're not sure where to go to get help, contact Blue Cross Blue Shield Global Core at 800-810-2583 (or call collect at 804-673-1177). They can direct you to the nearest medical facility.

You may need to pay upfront for care, but you will be reimbursed. You will have to submit a Global Core claim reimbursement form and copies of your itemized bills to **BCBSGlobalCore.com**. You can find the international claim form at **messa.org/forms**.

For non-emergency care:

Call Blue Cross Blue Shield Global Core at 800-810-2583 to find a hospital or authorized healthcare provider. You may have to pay for all costs upfront. You can submit a claim reimbursement form and send it with any itemized bills to MESSA for review.

Contacting MESSA from outside the U.S.

From the U.S. Virgin Islands, Puerto Rico, Canada and Guam: 800-380-3251.

From other foreign countries: 1-517-999-4557. You will need the U.S. 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.

Plan feature	In-network
Annual deductible	$375 individual/$750 family
Medical copayment	— $10 Blue Cross Online Visit — $25 office visit (e.g., primary care physician, obstetrics and gynecology, pediatric visits) — $25 chiropractic and osteopathic manipulations — $50 specialist visit — $50 urgent care — $200 emergency room
Medical coinsurance	20%
Prescription drug coverage	Essentials by MESSA
Annual out-of-pocket maximum	Amount is set at the annual federal limit.

Deductibles

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

There are separate in-network and out-of-network deductibles. 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.
NOTE: There is no fourth quarter carryover provision for the Essentials by MESSA plan.

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 medical service (after deductible) or prescription drug until the out-of-pocket maximum is reached.

Annual out-of-pocket maximum

The out-of-pocket maximum is the most you have to pay for covered services in a calendar year, including deductibles, 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.

Cost share for behavioral health

You pay the same cost share (deductible, copayment or coinsurance) for mental health and substance use disorder services that you would for all other covered services, in-network or out-of-network. MESSA/BCBSM considers some mental health and substance use disorder services to be in the same category as a physician's office visit. When that is the case, you pay only what you would for an office visit.

Alphabetical listing of specific covered services

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

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 benefit levels, log in to your MyMESSA 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), psychological testing, evaluation or therapy for allergies and 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, log in to your MyMESSA account at **messa.org**.*	

Covered services include transportation by licensed ambulance to or from the nearest hospital equipped to furnish treatment. Benefits are also available for emergency transportation by air ambulance to the nearest hospital equipped to furnish treatment.

Non-emergent air ambulance transportation requires prior authorization. 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 applies 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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

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).

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.

Autism Spectrum Disorders

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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

Autism spectrum disorders (ASD) include autistic disorder, Asperger's syndrome and autism pervasive developmental disorder not otherwise specified.

Applied Behavior Analysis services

Applied behavior analysis (ABA) is an evidence-based treatment for ASD that is covered under this plan.

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 licensed behavior analyst, who will then develop a detailed treatment plan specific to ABA treatment. The licensed behavior analyst 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 licensed behavior analyst registered with BCBSM, 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)
- Outpatient mental health therapy
- 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 30 visits.

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

Behavioral Health Services (Mental Health and Substance Use Disorder)*

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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

***Prior authorization is mandatory for all inpatient, residential and partial hospitalization services. We will not pay for services, admissions or lengths of stay that are not preapproved.**

We pay for medically necessary services to evaluate, diagnose, and treat mental health conditions, including substance use disorder. The services must be in accordance with generally accepted standards of practice and provided by an eligible provider.

We consider some behavioral health services to be in the same category as a physician's office visit. When that is the case, you pay what you would for an office visit.

Inpatient Hospital Services

We pay for the following inpatient services:

- Psychological testing
- Individual and group psychotherapeutic treatment
- Family counseling
- Inpatient consultations if a physician needs help diagnosing or treating a member's condition
- Acute detoxification

Psychiatric Residential Treatment

We pay for:

- Services provided by facility staff
- Individual and group psychotherapeutic treatment
- Family counseling for members of a patient's family
- Prescribed drugs given by the facility

We do not pay for:

- 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

- 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
- Treatment or supplies that do not meet BCBSM/MESSA requirements
- 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 an 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.

Residential and Outpatient Substance Abuse Rehabilitation Facility Treatment Services

We pay for the following services provided and billed by an approved program:

- Laboratory and diagnostic services
- Supplies and equipment used for subacute detoxification or rehabilitation
- Professional and trained staff services and program services necessary for care and treatment
- Individual and group therapy or counseling
- Therapy or counseling for family members
- Psychological testing

We pay for the following in a residential substance abuse treatment program:

- Room and board
- General nursing services
- Drugs, biologicals and solutions used in the facility

We pay for the following in an outpatient substance abuse treatment program:

- Outpatient substance use disorder services for the treatment of tobacco dependence
- Drugs, biologicals and solutions, including drugs taken home

We do not pay for:

- Dispensing methadone or testing of urine specimens unless you are receiving therapy, counseling or psychological testing while in the program
- Diversional therapy
- Services provided beyond the period necessary for care and treatment
- Treatment or supplies that do not meet MESSA/BCBSM requirements

Psychiatric Partial Hospitalization (PHP) Treatment Program

We pay for:

- Services provided by the hospital's or facility's staff
- Ancillary services
- Prescribed drugs given by the hospital or facility during the patient's treatment
- Individual and group psychotherapeutic treatment
- Psychological testing
- Family counseling

Psychiatric Intensive Outpatient Program (IOP)

We pay for:

- Services provided by the hospital's or facility's staff
- Ancillary services
- Individual and group psychotherapeutic treatment

- Family counseling

We do not pay for:

- Prescribed drugs given by the hospital or facility during the member's treatment
- Psychological testing

Outpatient Psychiatric Care Facility and Office Setting

We pay for:

- Services provided by the facility's staff
- Services provided by a qualified provider in a participating outpatient psychiatric care facility or an office setting:
  - » Individual psychotherapeutic treatment
  - » Family counseling
  - » Group psychotherapeutic treatment
  - » Psychological testing
- Prescribed drugs given by the facility in connection with treatment
- A partial hospitalization program as described in the PHP section of this document

We do not pay for:

- Services provided in a skilled nursing facility or through a residential substance abuse treatment program
- Marital counseling
- Consultations required by a facility or program's rules

Substance Use Disorder Partial Hospitalization Program (PHP)

We pay for:

- Services provided by the hospital's or facility's staff
- Ancillary services
- Prescribed drugs given by the hospital or facility during the member's treatment
- Individual and group psychotherapeutic treatment
- Psychological testing if it is directly related to the condition for which the member is admitted or has a full role in rehabilitative or substance use disorder treatment programs
- Family counseling

Substance Use Disorder Intensive Outpatient Program (IOP)

We pay for:

- Services provided by the hospital's or facility's staff
- Ancillary services
- Individual and group psychotherapeutic treatment
- Family counseling

We do not pay for:

- Prescribed drugs given by the hospital or facility during the member's treatment
- Psychological testing

Bone marrow transplants*

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Coinsurance applies after deductible is met	— Deductible — Coinsurance applies after deductible is met	— Not covered
*For your plan's specific benefit levels, log in to your MyMESSA account at **messa.org**.*		

***Prior authorization 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.**

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-Blackfan 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 healthcare 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
- Any services related to, or for, allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements
- 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

Cellular and gene therapy*

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Copayment may apply — Coinsurance applies 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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

***Prior authorization may be required.**

Cellular and gene therapies are products that involve the use of human cells and/or genetic modification to treat disease.

We pay for:

- Cellular and gene therapies for cancer indications.
  - » Coverage is not limited for antineoplastic or off-label drugs when Michigan law requires that they, and the reasonable cost of their administration, be covered.
- Cellular and gene therapies for non-cancer indications that have been proven to be effective, as determined by MESSA/BCBSM.
  - » MESSA/BCBSM considers cellular and gene therapies to be proven effective to treat a condition if the following are true:
    - — The drug has full FDA approval that was not obtained under the FDA's accelerated approval pathway; and
    - — The drug met all of its primary endpoint(s) in its pivotal trials; or
    - — If confirmatory trials were required, the drug met its primary endpoint(s) in its confirmatory trial(s).

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 applies 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 benefit levels, log in to your MyMESSA 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

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 – see Spinal manipulations

Colonoscopy – Medically necessary

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Coinsurance applies 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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

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.

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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

We pay for 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 – Medically necessary

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Coinsurance applies 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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

Cosmetic surgery is only payable when medically necessary 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 when medically necessary to treat the injury.
- Traumatic scars.

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

Dental surgery

What you pay for covered services	
There is currently no network; in-network (IN) benefits apply	
Participating provider	**Nonparticipating provider**
— IN deductible — IN coinsurance applies after deductible is met	— IN deductible — IN coinsurance applies after deductible is met — Charges in excess of approved amount
*For your plan's specific benefit levels, log in to your MyMESSA account at **messa.org**.*	

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

- Accidental injury to sound natural teeth within 24 hours of the injury.
- The removal of cysts and tumors of the mouth and jaw.
- Multiple extractions or removal of unerupted teeth or alveoplasty when:
  - » A hospitalized patient has a dental condition that is adversely affecting a medical condition, and
  - » Treatment of the dental condition is expected to improve the medical condition.

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

Diabetic supplies

What you pay for covered services	
There is currently no network; in-network (IN) benefits apply	
Participating provider	**Nonparticipating provider**
— IN deductible may apply — 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, log in to your MyMESSA account at **messa.org**.*	

We pay for select medical supplies to treat and control diabetes when medically necessary and prescribed by an M.D. or D.O. To receive reimbursement for supplies purchased out-of-pocket, you must have a prescription from your physician and a receipt of the items purchased. Follow the instructions under **How to File a Medical Claim**.

Covered diabetic supplies include:

- Blood glucose monitors
- Blood glucose monitors for the legally blind
- Insulin pumps
- Test strips for glucose monitors
- Visual reading and urine test strips
- Lancets
- Spring-powered lancet devices
- Syringes
- Insulin
- Medical supplies required for the use of an insulin pump
- Nonexperimental drugs to control blood sugar
- Medication prescribed by a doctor of podiatric medicine, M.D. or D.O. that is used to treat foot ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes

*NOTE: If you receive diabetic supplies paid by your MESSA prescription drug plan, your MESSA medical plan will not pay for the same diabetic supplies and devices. A complete list of eligible pharmacy prescription diabetic supplies and devices is available on our website at **messa.org**.*

Diagnostic services

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Coinsurance applies 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 benefit levels, log in to your MyMESSA 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 applies 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 benefit levels, log in to your MyMESSA 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.

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 applies after deductible is met	— IN deductible — IN coinsurance applies after deductible is met — Charges in excess of approved amount
*For your plan's specific benefit levels, log in to your MyMESSA account at **messa.org**.*	

A prescription for DME from a qualified provider is required. The rental or purchase of DME is limited to basic equipment plus medically necessary special features as prescribed. DME must be obtained from approved providers. Items obtained from online retailers are generally not covered. Call MESSA's Member Service Center at 800-336-0013 before renting or purchasing DME to verify if the DME supplier is approved and the equipment will be covered.

Emergency room (ER) – Facility charges

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — ER copayment	— IN deductible — ER copayment	— IN deductible — ER copayment — Charges in excess of approved amount
*For your plan's specific benefit levels, log in to your MyMESSA account at **messa.org**.*		

Emergency room (ER) – Physician charges

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible	— IN deductible	— IN deductible — Charges in excess of approved amount
*For your plan's specific benefit levels, log in to your MyMESSA account at **messa.org**.*		

The ER copayment will be waived if the patient is treated for an accidental injury or is admitted to the hospital. Emergency services treat medical emergencies and accidental injuries. Non-emergency use of the emergency room may not be covered.

A **medical emergency** is 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. Emergency services treat medical emergencies.

An **accidental injury** is 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
- Poisoning
- Drug overdosing
- Inhaling smoke, carbon monoxide or fumes
- Attempted suicide
- A dental accidental injury occurring when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, periodontal structures (gums) or bone

End Stage Renal Disease (ESRD)

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Coinsurance applies 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 benefit levels, log in to your MyMESSA 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 **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.

Fertility preservation

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Coinsurance applies 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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

Fertility preservation services are covered only for members with malignant cancer diagnosis when undergoing fertility-threatening medical or radiation therapies and treatments.

Fertility preservation treatment and services include, but are not limited to:

- Collection of mature eggs and sperm
- Cryopreservation of embryos, mature eggs and sperm
- Storage of embryos, mature eggs and sperm for up to one year
- Thawing of embryos, mature eggs and sperm within one year of procurement
- Culture of eggs
- Ovarian transposition
- Embryo transfer to member within one year from cryopreservation

We do not pay for:

- Storage of sperm, eggs or embryos for longer than one year
- Co-culture of embryo(s)
- Post-menopausal members
- Members who have undergone elective sterilization (vasectomy, tubal sterilization), with or without reversal

Gender affirming 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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

We pay for medically necessary services, both professional and facility, for the treatment of gender dysphoria. This requires a clinical diagnosis based on criteria set out in the current Diagnostic and Statistical Manual of Mental Disorders. These services may include hormone treatment and gender affirming surgery, as well as counseling and behavorial health services.

We do not pay for gender affirming services that are considered by MESSA/BCBSM to be cosmetic or for treatment that is experimental or investigational.

Hearing care services – M.D. or D.O.

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Coinsurance applies 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 benefit levels, log in to your MyMESSA 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.

Hearing care services – Audiologist

What you pay for covered services	
There is currently no network; in-network (IN) benefits apply	
Participating provider	**Nonparticipating provider**
— IN deductible — IN coinsurance applies after deductible is met	— IN deductible — IN coinsurance applies after deductible is met — Charges in excess of approved amount
*For your plan's specific benefit levels, log in to your MyMESSA 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.

Hemodialysis

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Coinsurance applies after deductible is met	— Deductible — Coinsurance applies after deductible is met	— Not covered unless in a home hemodialysis program
*For your plan's specific benefit levels, log in to your MyMESSA account at **messa.org**.*		

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

Home healthcare

What you pay for covered services	
There is currently no network; in-network (IN) benefits apply	
Participating provider	**Nonparticipating provider**
— IN deductible — IN coinsurance applies after deductible is met	— IN deductible — IN coinsurance applies after deductible is met — Charges in excess of approved amount
*For your plan's specific benefit levels, log in to your MyMESSA 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 healthcare agency.

To qualify for this benefit, a covered person must have physician certification assuring home healthcare 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 rendered by a registered nurse or a licensed practical nurse; full-time care is not covered.
- Medical care rendered by a home health aide or nurse's assistant under the direct supervision of a registered nurse.
- Physical therapy, occupational therapy, speech therapy, social service guidance and nutritional guidance provided by a home healthcare 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.

Meals, general housekeeping services, transportation, comfort items 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 services are payable for as long as medically necessary to treat the patient's condition. To be payable, the following criteria must be met:

- The patient or their representative elects hospice care services in writing. This written statement must be filed with a participating hospice program.
- A written certification stating the member is terminally ill, that is signed by the hospice program's medical director or a physician of the hospice interdisciplinary group and the attending physician (if you have one), is kept on file in the patient's medical record.

- The hospice program's medical director or a physician of the hospice interdisciplinary group evaluates and recertifies the treatment plan every 90 days.

The member, or their representative, must sign a "Waiver of Benefits" form acknowledging that the patient has been given a full explanation of hospice care. The waiver explains that MESSA does not pay for treatment of the terminal illness itself or related conditions during hospice care.
*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 their 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 by a registered nurse; full-time care is not included
- 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

Hospital care

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Coinsurance applies 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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

After you have followed the pre-admission review requirements, and your admission has been determined by MESSA to be medically necessary, benefits will be paid as follows:

Inpatient Hospital Services

- Medical care by hospital personnel while you are receiving inpatient services.
- Semiprivate room
- Nursing services
- Meals, including special diets
- Services provided in a special care unit, such as intensive care
- Oxygen and other therapeutic gases and their administration
- Inhalation therapy
- Electroconvulsive Treatment (ECT)
- Pulmonary function evaluation
- Whole blood, blood derivatives, blood plasma or packed red blood cells, supplies and their administration

- Hyperbaric oxygenation (therapy given in a pressure chamber)

Outpatient Hospital Services

If a service is payable as an inpatient service, it is also payable as an outpatient service. (Exceptions are services related to inpatient room, board, and inhalation therapy).

Scheduled Outpatient Surgery

Hospital charges for covered scheduled outpatient surgery are payable.

If a service is payable as an inpatient service, it is also payable as an outpatient service. (Exceptions are services related to inpatient room, board, and inhalation therapy). In addition, the following services are payable:

- Repeated visits to the hospital to treat chronic conditions

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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

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

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 (meals not covered) 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 healthcare plan

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

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 MESSA/BCBSM 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 (cornea and skin)

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Coinsurance applies after deductible is met	— Deductible — Coinsurance applies after deductible is met	— Not covered
*For your plan's specific benefit levels, log in to your MyMESSA account at **messa.org**.*		

Services for cornea and skin transplants are covered as standard benefits and are not limited to specific transplant facilities. Living donor and recipient services are paid under the recipient's coverage. To be payable, the recipient must be a MESSA member. We pay for services performed to obtain, test, store and transplant the organs.

Mammography – Medically necessary

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Coinsurance applies 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 benefit levels, log in to your MyMESSA 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.

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 benefit levels, log in to your MyMESSA 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.

Maternity care – Delivery, ultrasounds and certain labs

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Coinsurance applies 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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

We pay for obstetrical services, including delivery, as well as maternity care benefits when provided by a physician or a certified nurse midwife at a BCBSM-approved birth center.

Newborn Care

Under federal law, we generally may not restrict benefits for any hospital length of stay in connection with childbirth for a newborn child to less than:

- 48 hours following a vaginal delivery
- 96 hours following a delivery by cesarean section

The same benefits with the same cost-sharing levels are covered during the 48 or 96 hours. In addition, we may not require that a physician or other provider get approval for a length of stay of up to 48 hours (or 96 hours, as applicable).

We pay for newborn services provided only during the 48 hours or 96 hours if the newborn has not been added to a MESSA contract. These services include:

- Newborn examination given by a physician other than the anesthesiologist or the birth parent's attending physician
- Routine care during the newborn's eligible hospital stay
- Services to treat a newborn's injury, sickness, congenital defects or birth abnormalities

NOTE: If the newborn is eligible for coverage as a dependent under another healthcare benefit plan and has been added as a dependent to that plan, newborn services are not covered under the MESSA contract.

Maternity care – Prenatal and postnatal preventive care

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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

Medical Case Management (MCM) claims

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Coinsurance applies 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 benefit levels, log in to your MyMESSA 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 healthcare. The nurse will support you and may help you obtain necessary healthcare.

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:

- 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)
- Cancer
- Other serious medical conditions

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

Eligibility must be determined by a MESSA nurse before benefits can begin. If you have any questions regarding MCM, please contact MESSA at 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 applies after deductible is met	— IN deductible — IN coinsurance applies after deductible is met — Charges in excess of approved amount
*For your plan's specific benefit levels, log in to your MyMESSA 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). Quantity limits may apply. Medical supplies must be purchased from a payable durable medical equipment (DME) provider. Contact MESSA Member Services at 800-336-0013 or TTY: 888-445-5614 to inquire whether coverage is available for your medical supplies.

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. These visits must be performed by an M.D. or D.O.

Obstetrics – see Maternity care

Occupational therapy – see Therapy services

Office, outpatient, and home physician visits

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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

Oncology clinical trials*

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Coinsurance applies after deductible is met	— Deductible — Coinsurance applies after deductible is met	— Not covered
*For your plan's specific benefit levels, log in to your MyMESSA account at **messa.org**.*		

***Prior authorization 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.

    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
- Use of transition technologies as a routine service in an approved clinical trial such as cellular or gene therapies that have not been FDA approved for those indications
- Routine patient costs for Phase I clinical trials whose primary purpose is not for therapeutic intent
- 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 healthcare coverage will pay
- Non-healthcare 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 – see Spinal manipulations

Physical therapy – see Therapy services

Prescription drugs

Please refer to the Essentials by MESSA prescription coverage booklet at **messa.org**.

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.

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 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 — IN coinsurance applies after deductible is met	— IN deductible — IN coinsurance applies after deductible is met — Charges in excess of approved amount
*For your plan's specific benefit levels, log in to your MyMESSA account at **messa.org**.*	

***Prior authorization is mandatory. We will not pay for services that are not preapproved.**

We pay for private duty nursing services in your home or in a hospital up to a maximum of 16 hours per day if it is:

- Ordered by a physician, M.D. or D.O. who is involved in your ongoing care
- Skilled care given by a professional registered nurse or licensed practical nurse
- Medically necessary as determined by MESSA
- Given in a hospital, because the hospital lacks intensive or cardiac care units or has no space in such units

All progress notes must be submitted with the claim form.

We do not pay for:

- Care given by a private duty nurse that is related to you or lives in your home
- Maintenance care after your condition has stabilized
- More than 16 hours per day of skilled care
- Skilled care given outside your home
- Custodial care
- Respite care
- Lifetime care

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 applies after deductible is met	— IN deductible — IN coinsurance applies after deductible is met — Charges in excess of approved amount
*For your plan's specific benefit levels, log in to your MyMESSA 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 and purchased from a payable durable medical equipment (DME) provider. Repairs or replacements are covered due to wear and tear or growth. Quantity limits apply.

Benefits include, but are not limited to:

- External breast prostheses following a mastectomy, including two post-surgical brassieres per 12-month period; additional brassieres are covered if there is a significant change in body weight or for hygienic reasons
- One wig per 12-month period for hair loss for certain medical conditions
- Artificial eyes, ears, nose, larynx, limbs
- 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

- Orthopedic shoes and prefabricated custom-made orthotic devices that meet MESSA guidelines. This benefit is subject to the following:
  - » Coverage is limited to the approved amount for a participating provider.
  - » Quantity and frequency limitations will reset each calendar year.
  - » The provider must provide documentation that details how the shoe was customized in order to be eligible for reimbursement.
- 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 applies 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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

*** Prior authorization may be required.**

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)
- Positron emission tomography

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.

Skilled nursing care – Facility charges

What you pay for covered services	
There is currently no network; in-network (IN) benefits apply	
Participating provider	**Nonparticipating provider**
— IN deductible — IN coinsurance applies after deductible is met	— Not covered
*For your plan's specific benefit levels, log in to your MyMESSA account at **messa.org**.*	

We pay for facility and professional services in a skilled nursing facility. Admission to the skilled nursing facility must be ordered by your attending physician and we require written confirmation from your physician that skilled care is needed. We pay only for the length of stay that is necessary for the proper care and treatment of the patient, up to a maximum of 120 days per member, per calendar year.

We pay for:

- A semiprivate room, including general nursing service, meals and special diets
- Special treatment rooms
- Laboratory examinations
- Oxygen and other gas therapy
- Drugs, biologicals and solutions
- Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts
- Durable medical equipment used in the facility or outside the facility when rented or purchased from the skilled nursing facility
- Physician services (up to two visits per week)
- Physical therapy, speech language therapy services or occupational therapy when medically necessary
  - » The physical and occupational therapy or speech language therapy services that are done in a skilled nursing facility are inpatient benefits. The 30-visit benefit maximums apply only when these services are provided on an outpatient basis.

We do not pay for:

- Custodial care or domiciliary care
- Care for senility or developmental disability
- Care for substance use disorder
- Care for mental illness (other than for short-term nervous and mental conditions to which the 120-day maximum applies)

Speech therapy – see Therapy services

Spinal manipulations

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Copayment applies — 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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

We pay for spinal manipulations to treat misaligned or displaced vertebrae of the spine. These services must be performed by a doctor of osteopathic medicine (D.O.) or by a chiropractor. If the manipulation is rendered by a chiropractor, there must be a treatment plan for chiropractic care prepared by the chiropractor and signed by the member's M.D. or D.O., on file. There is a combined annual limit of 12 covered visits.

For therapeutic massage benefits, see the **Therapy services** section.

Surgical services

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Coinsurance applies 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 benefit levels, log in to your MyMESSA 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 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 applies 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 benefit levels, log in to your MyMESSA 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

Telehealth

MESSA covers three different types of telehealth. Please read all three Telehealth sections to understand the difference, and ensure you choose the appropriate benefit for your healthcare needs.

Telehealth – Teladoc Health

What you pay for covered services	
In-network (IN)	**Out-of-network (OON)**
— Deductible — Copayment applies after deductible is met	— Not presently available
Note: Teladoc Health is the only covered vendor.	
*For your plan's specific benefit levels, log in to your MyMESSA account at **messa.org**.*	

We pay for the diagnosis, treatment and consultation recommendations for minor illnesses, injuries and mental health care via the Teladoc Health website or app.

Treatment and consultation recommendations made during a Teladoc Health appointment, including issuing a prescription, must be within the provider's scope of practice and are to be held to the same standards of appropriate practice as those in traditional settings. The provider must be licensed in the state where the patient is located during the appointment.

Telehealth – Teladoc Virtual Primary Care

What you pay for covered services	
In-network (IN)	**Out-of-network (OON)**
— Deductible — Copayment applies after deductible is met	— Not presently available
Note: Teladoc Health is the only covered vendor.	
*For your plan's specific benefit levels, log in to your MyMESSA account at **messa.org**.*	

We pay for Teladoc Virtual Primary Care Visits for members who are 18 or older. Teladoc Virtual Primary Care services are provided through Teladoc Health's website or secure digital app, including messages, telephone and video calls.

Teladoc Virtual Primary Care visits include a broad range of primary care provider services, including managing and coordinating your healthcare for chronic and non-urgent conditions.

The in-network cost share for a Teladoc Virtual Primary Care visit is the same as the in-network cost share you pay for an in-person primary care provider visit.

Telehealth – Telemedicine

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Copayment and/or coinsurance applies 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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

We pay for real-time medical and behavioral health care services delivered via telephone, internet, or other electronic technology when you're not in your provider's presence. To be covered, the service must be medically necessary and performed by a payable provider. Contact for these services can be initiated by you or your provider, and must be within your provider's scope of practice.

Therapy services

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Coinsurance applies 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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

Therapy services include, but are not limited to:

- Physical therapy
- Occupational therapy
- Speech therapy
- Therapeutic modalities (including therapeutic massage)

There is a combined annual limit of 30 visits per member, per calendar year, whether obtained from an in-network or out-of-network provider. The benefit maximum renews each calendar year.

All services provided in the outpatient department of a hospital, doctor's office or freestanding facility are combined to meet the annual limit. Therapy rendered in an inpatient hospital setting is not subject to the annual limit.

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.

Physical therapy

Services must be performed by:

- A doctor of medicine, osteopathy, podiatry or chiropractic
- 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.

Therapeutic modalities

Therapeutic modalities include electrical stimulation, mechanical traction, application of hot and cold treatment and therapeutic massage.

Services must be performed by:

- A doctor of medicine or osteopathy

- A licensed physical therapist
- An occupational therapist
- A doctor of chiropractic
  - » Therapeutic massage rendered by a chiropractor

is only covered when billed with another service performed on the same day as the massage and there is a treatment plan for chiropractic care, prepared by the chiropractor and signed by the member's M.D. or D.O., on file.

Urgent care

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Urgent care copayment	— 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 benefit levels, log in to your MyMESSA account at **messa.org**.*		

Vision therapy

What you pay for covered services		
In-network (IN)	**Out-of-network (OON)**	**Nonparticipating provider**
— Deductible — Coinsurance applies 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 benefit levels, log in to your MyMESSA 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 applies 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 benefit levels, log in to your MyMESSA 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	— OON deductible — OON coinsurance applies after deductible is met — Charges in excess of approved amount
*For your plan's specific benefit levels, log in to your MyMESSA account at **messa.org**.*		

Reversal of sterilization procedures is not covered.

Well baby/well child care – see Preventive services

Exclusions and limitations

The following exclusions and limitations apply to the Essentials by MESSA 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 an employer
- Charges toward your deductible or coinsurance requirements for in-network, out-of-network and non-participating providers that:
  - » Exceed our approved amount
  - » Are for non-covered and limited covered services
  - » Apply to deductibles, prescription copayments or coinsurance paid under other plans
- Services provided in a Veterans Administration Hospital for a covered person with military service-connected disability
- Services, supplies or treatments provided or covered under any governmental plan or law or which would have been furnished without cost in the absence of this coverage or for which the covered person has no legal obligation to pay

NOTE: Federal laws may require a government-sponsored program to be secondary. If so, we pay for care and services.

- 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, extraction of impacted or unerupted teeth (e.g. wisdom teeth) unless the patient is hospitalized with a concurrent hazardous medical condition, 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 provided by the BCBSM or MESSA medical director
- 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 **Preventive Care Services** section)
- 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 accepted standards of medical practice including any services which are experimental or investigational in nature

NOTE: Medical research and technological advances are ongoing. Some procedures that were considered experimental may become generally accepted standard treatments. To be covered under this plan, these procedures must be recognized as a standard of care. They must be medically necessary for the illness or injury being treated.

- Surgery for cosmetic or beautifying purposes, except for the correction of conditions resulting from an accidental injury or from an illness
- Gender affirming services that are considered by MESSA/BCBSM to be cosmetic, or treatment that is experimental or investigational
- Healthcare services provided by persons who are not legally qualified or licensed to provide such services
- Services that are not MESSA benefits

- Radiology procedures not directly related and necessary to diagnose the disease, illness, pregnancy or injury (such as an ultrasound solely to determine the gender of the fetus)
- Services, care, supplies or devices not prescribed by a physician
- Self-administered, over-the-counter drugs
- 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
- Noncontractual services that are described in your case management treatment plan or any other treatment plan, if the services have not been approved by MESSA/BCBSM
- Speech and language pathology services to treat chronic conditions, congenital or inherited speech abnormalities, developmental conditions or learning disabilities except for children
- Any treatment that is not a covered benefit by us
- Therapeutic massage performed by a massage therapist
- Bariatric surgery
- Acupuncture
- Hearing aids
- Services performed by a registered dietitian
- Weight loss or weight control treatment (other than obesity screening required by the ACA), such as Weight Watchers, Jenny Craig, Medical Weight Loss Clinic or gym memberships
- Non-participating facility charges unless for emergency services
- Charges from facilities that terminate participation with BCBSM unless for emergency services, designated services or continuity of care services
- 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.

- Non-emergency and non-urgent care services for members traveling outside of the United States. Coverage for members traveling outside of the United States is limited to medical emergencies and urgent care services.
- Services for eye surgeries such as, but not limited to, LASIK, PRK or RK performed to correct visual acuity

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:

Step 1: Ask the provider for an itemized statement with the following instructions:

- Patient's name and birth date
- Subscriber's name, address, phone number and contract number (from your MESSA 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

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

Step 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 subscriber'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**"), please send your bill to MESSA along with a copy of the other carrier's explanation of benefits.*

MESSA will send you an explanation of benefits (EOB) document when a claim is processed. Please keep these EOBs for future reference.

To find out if an out-of-area provider is a participating provider, please call 800-336-0013 or TTY: 888-445-5614.

You may also use the use the Find Care tool at **messa.org** 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 or coinsurance that may apply.

Grievance process

MESSA wants you to be satisfied with the services you receive as a member. If you have a question or concern about how we processed your claim or request for benefits, we encourage you to contact our Member Service Center at 800-336-0013 or TTY: 888-445-5614.

Eligibility Grievance Process

You or your authorized representative may send us a written statement explaining why you disagree with our decision regarding your eligibility or rescission of your coverage. Your request for review must be submitted within 180 days after receiving a notice of denial.

Mail your written grievance to:

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

We have 60 days to give you our final determination. You have the right to allow us additional time if you wish.

A decision will be made by MESSA after we receive your request for review or the date you provide all information required of you, whichever date is later. The decision will be in writing and will specify the reason for MESSA's decision.

If you disagree with our final decision, or you do not receive our decision within 60 days, you may request an external review. See below for how to request an external review.

Grievance and Appeals Process

We have a formal grievance and appeals process that allows you to dispute an adverse benefit decision or rescission of your coverage.

An adverse benefit decision includes a:

- Denial of a request for benefits
  - » A utilization review revealed the benefit should not have been paid.
  - » We determined the service to be experimental, investigational or not medically necessary or appropriate.
- Reduction in benefits
- Failure to pay for a service or
- Failure to respond in a timely manner to a request for a determination

You may file a grievance or appeal about any adverse benefit decision within 180 days after you receive the claim denial. The dollar amount involved does not matter.

If you file a grievance or appeal:

- You will not have to pay any filing charges.
- You may submit materials or testimony at any step of the process to help us in our review.
- You may authorize another person, including your

physician, to act on your behalf at any stage in the standard review process. Your authorization must be in writing. Please call the MESSA Legal and Compliance Department at 800-742-2328 or TTY: 888-445-5614 and ask for a Designation of Authorized Representative and Release of Information form. Complete it and send it with your appeal.

- You do not have to pay for copies of information relating to MESSA/BCBSM's decision to deny, reduce, terminate or cancel your coverage.

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.

You do not have to exhaust our internal grievance process before requesting an external review in certain circumstances:

- We waive the requirement.
- We fail to comply with our internal grievance process.
  - » Our failure to comply must be for more than minor violations of the internal grievance process. Minor violations are those that do not cause and are not likely to cause you prejudice or harm.

Note: If your grievance or appeal relates to an adverse benefit determination that is subject to Public Act 60 *(MCL* 500.2212*e), proceed to Step* 2 *of the Standard Internal Grievance Process.*

Standard Internal Grievance Process

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

Mail your written grievance to:

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

- For pre-service appeals, we have 15 days to give you our final determination.
- For post-service appeals, we have 30 days to give you our final determination.

In both cases, you have the right to allow us additional time if you wish.

A decision will be made by MESSA/BCBSM after MESSA receives your request for review or the date you provide all information required of you, whichever date is later.

The decision will be in writing and will specify the reason for MESSA/BCBSM's decision.

Step 2: If you are dissatisfied with this decision, you may request a managerial-level conference by calling the MESSA Legal and Compliance Department at 800-742-2328 or mailing your written request to:

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

During your conference, you can provide us with any other information you want us to consider in reviewing your grievance. You can choose to have the conference in person or over the telephone. If in person, the conference will be held at the BCBSM headquarters in Detroit during regular business hours. The written decision we give you after the conference is our final decision.

- For pre-service appeals, we have 15 days to give you our final determination.
- For post-service appeals, we have 30 days to give you our final determination.

In both cases, you have the right to allow us additional time if you wish.

BCBSM and MESSA will complete both steps within 30 days of the date we receive your written grievance under Step 1 for pre-service appeals, and within 60 days for post-service appeals. These time periods do 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 decision, or you do not receive our decision within 30 days after we received your original grievance for a pre-service appeal, or within 60 days for a post-service appeal, you may request an external review. See below for how to request an external review.

Standard External Review Process

Once you have gone through our standard internal review process, you or your authorized representative may request an external review.

Within 120 days of the date you receive or should have received our final decision, send a written request for an external review to the Department of Insurance and Financial Services (DIFS) listed below. Mail your request and the required forms that we give you to:

Department of Insurance and Financial Services Office of Research, Rules, and Appeals
Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

You may have your request delivered by courier or delivery to:

Department of Insurance and Financial Services
530 W. Allegan Street, 7th Floor
Lansing, MI 48933

You may also contact DIFS with your request by phone, fax, or online:

Phone: 877-999-6442
Fax: 517-284-8838
Email: **DIFS-HealthAppeal@michigan.gov**
Online:
difs.state.mi.us/Complaints/ExternalReview.aspx

When you file a request for an external review, you will have to authorize the release of medical records that may be required to reach a decision during the external review.

If you ask for an external review about a medical issue and the issue is found to be appropriate for external review, DIFS will assign an independent review group to conduct the external review. The group will consist of independent clinical peer reviewers. The recommendation of the independent review group will only be binding on you and MESSA/BCBSM if DIFS decides to accept the group's recommendation. The department will make sure that this independent review group does not have a conflict of interest with you, with us, or with any other relevant party.

Review of Medical Issues

DIFS will assign an independent review group to review your request if it concerns a medical issue that is appropriate for an external review.

- You can give DIFS additional information within seven business days of requesting an external review. We must give the independent review group all of the information we considered when we made a final decision within seven business days of getting notice of your request from DIFS.

The review group will recommend within 14 days whether DIFS should uphold or reverse our decision. DIFS must decide within seven business days whether to accept the recommendation and then notify you of its decision. The decision is your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Review of Nonmedical Issues

If your request for an external review is related to nonmedical issues and is appropriate for external review, DIFS staff will recommend whether our determination should be upheld or reversed.

DIFS will notify you of the decision. This is your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Expedited Internal Review Process

You may file an expedited internal review request if your physician shows (verbally or in writing) that following the timeframes of the standard internal process will seriously jeopardize:

- Your life or health, or
- Your ability to regain maximum function

To submit a request for an expedited internal review, call 800-742-2328, option 4, or TTY: 888-445-5614. Your physician must also call this number to confirm that you qualify for an expedited review.

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 DIFS.

If you believe your situation is urgent, you may request an urgent review or a simultaneous expedited external review.

For more information on how to ask for an urgent review or simultaneous expedited external review, call the MESSA Legal and Compliance Department at 800-742-2328 or TTY: 888-445-5614.

Expedited External Review Process

If you have filed a request for an expedited internal grievance, you may concurrently request an expedited external review from DIFS. Otherwise, the process is as follows:

- A request for external review form will be sent to you or your representative with our final adverse determination.
- Within 10 days of receiving your denial, complete this form and mail it to:

Department of Insurance and Financial Services Office of Research, Rules, and Appeals
Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

You may have your request delivered by courier or delivery to:

Department of Insurance and Financial Services
530 W. Allegan Street, 7th Floor
Lansing, MI 48933

You may also contact DIFS with your request by phone, fax, or online:

Phone: 877-999-6442
Fax: 517-284-8838
Email: **DIFS-HealthAppeal@michigan.gov**
Online:
difs.state.mi.us/Complaints/ExternalReview.aspx

When you file a request for an external review, you will have to authorize the release of medical records that may be required to reach a decision during the external review.

- DIFS will decide if your request qualifies for an expedited review. If it does, DIFS will assign an independent review group to conduct the review. The group will recommend within 36 hours if DIFS should uphold or reverse our decision.
- DIFS must decide whether to accept the recommendation within 24 hours. You will be told of the decision. This decision is the final administrative decision under the Patient's Right to Independent Review Act of 2000.

Need More Information?

At your request and without charge, we will send you details from your healthcare 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 MESSA Legal and Compliance Department at 800-742-2328 or TTY: 888-445-5614. You can also contact the director of the Michigan Department of Insurance and Financial Services for assistance.

To contact the Director:

- Call toll-free at 877-999-6442
- Fax at 517-284-8838
- Email at **DIFS-HealthAppeal@michigan.gov**
- Online at:
  difs.state.mi.us/Complaints/ExternalReview.aspx

Mail to:
Department of Insurance and Financial Services
P.O. Box 30220
Lansing, MI 48909-7720

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.

Coordination of benefits

We will coordinate benefits payable under this plan pursuant to the Michigan's Coordination of Benefits Act (starting at MCLA 550.251). Coordination of benefits is used when you are eligible for payment under more than one group insurance plan. This provision ensures that your covered expenses will be paid. The combined payments will not exceed the actual cost, nor the amount that you would have paid.

We do not pay any cost-sharing that you must pay under any other plan, subject to coordination of benefit requirements.

End Stage Renal Disease (ESRD)

We coordinate with Medicare to pay for ESRD treatment. You should apply for Medicare to keep costs down; otherwise you will be responsible for paying the cost of ESRD treatment.

When Medicare Coverage Begins

If you have ESRD, your Medicare starts on the first day of the fourth month of dialysis.

The time before Medicare coverage begins is the "Medicare waiting period." It lasts for three months.

- There is no waiting period if you begin self-dialysis training within three months of when your dialysis starts. If so, Medicare coverage begins the first day of the month you begin dialysis.
- There is no waiting period if you go in the hospital for a kidney transplant or services you need before the transplant. Medicare coverage begins the first day of the month you go in. You must receive your transplant within three months of going in the hospital.
- If your transplant is delayed more than two months after you go in the hospital, Medicare coverage begins two months before the month of your transplant.

Priority of MESSA Coverage

If you have MESSA group coverage through your job and you are entitled to Medicare because you have ESRD, MESSA is your primary plan. That means we pay for all covered services for up to 33 months. (The three-month "waiting period" and 30-month "coordination period".) After the coordination period, Medicare is your primary plan and pays for all covered services.

Dual Entitlement

If you have dual entitlement to Medicare and have MESSA coverage, the following applies:

- If you are entitled to Medicare because you have ESRD and your entitlement starts at the same time or before you are entitled to Medicare because of your age or disability, then MESSA is the primary plan. It is primary until the end of the 30-month coordination period.
- If you become entitled to Medicare because you have ESRD after you are entitled to Medicare because of your age or disability, MESSA is your primary plan for the 30-month coordination period if you are "working aged" or "working disabled".
- If you are not a working aged or working disabled individual in the first month of dual entitlement, Medicare is your primary plan.

Subrogation: When others are responsible for illness or injury

If MESSA/BCBSM paid claims for an illness or injury, and:

- Another person caused the illness or injury, or
- You are entitled to receive money for the illness or injury.

Then MESSA/BCBSM is entitled to recover the amount of benefits it paid on your behalf.

Subrogation is MESSA/BCBSM's right of recovery. MESSA/BCBSM is entitled to its right of recovery even if you are not "made whole" for all of your damages in the money you receive. MESSA/BCBSM's right of recovery is not subject to reduction of attorney's fees, costs, or other state law doctrines such as common fund.

Whether you are represented by an attorney or not, this provision applies to:

- You
- Your covered dependents

You agree to:

- Cooperate and do what is reasonably necessary to assist MESSA/BCBSM in the pursuit of its right of recovery.
- Not take action that may prejudice MESSA/BCBSM's right of recovery.
- Permit MESSA/BCBSM to initiate recovery on your behalf if you do not seek recovery for illness or injury.
- Contact MESSA/BCBSM promptly if you seek damages, file a lawsuit, file an insurance claim or demand or initiate any other type of collection for your illness or injury.

MESSA/BCBSM may:

- Seek a first priority lien on proceeds of your claim in order to fulfill MESSA/BCBSM's right of recovery.
- Request you to sign a reimbursement agreement.
- Delay processing of your claims until you provide a signed copy of the reimbursement agreement.
- Offset future benefits to enforce MESSA/BCBSM's right of recovery.

MESSA/BCBSM will:

- Pay the costs of any covered services you receive that are in excess of any recoveries made.
- Recover money it paid on your behalf if another person or insurance company is responsible:
  - When a third party injures you, for example, through medical malpractice;
  - When you are injured on premises owned by a third party; or
  - When you are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to medical reimbursement coverage.

Surprise Billing

Federal and Michigan law require MESSA/BCBSM to pay nonparticipating providers certain rates for covered services and prohibit those providers from billing you the difference between what we pay and what the provider charges. When the surprise billing laws apply, we will pay the provider directly, and you will only pay the cost share applicable to that service as defined in federal or Michigan law. The cost share you pay for these services will apply to your in-network deductible and in-network out-of-pocket maximum. The following situations are covered by the surprise billing laws:

- Covered emergency services at a participating or a nonparticipating facility
  - Emergency services are covered regardless of whether the facility is participating or nonparticipating.
  - If you receive emergency services rendered by a nonparticipating facility or provider, administrative requirements will be the same, regardless of the facility's participating status.
- Covered non-emergency services provided by nonparticipating providers in the following participating facilities: hospitals, critical access hospitals, hospital outpatient departments, and ambulatory surgical centers.
  - You can waive surprise billing protections if you sign a notice and consent form.
  - Certain "ancillary" providers are not allowed to ask you to waive your surprise billing protections. These include anesthesiologists, pathologists, emergency medicine providers, radiologists, neonatologists, hospitalists, and surgical assistants.
- Covered air ambulance services.

Release of Information

You agree to permit providers to release information to us. This can include medical records and claims information related to services you may receive or have received.

We agree to keep this information confidential. Consistent with our Notice of Privacy Practices, this information will be used and disclosed only as authorized by law.

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.

Reliance on verbal communications

If a MESSA representative verbally tells you a member is eligible for coverage or benefits are available, this does not guarantee your claims will be paid. Claims are paid only after:

- The reported diagnosis is reviewed
- Medical necessity is verified
- Benefits are available when the claim is processed

Right to interpret contract

During claims processing and internal grievances, MESSA/BCBSM reserves the right to interpret and administer the terms of this plan. MESSA/BCBSM's final adverse decisions regarding claims processing and grievances may be appealed under applicable law.

Temporary Benefits

We pay temporary benefits for some services when a participating professional provider, hospital or facility ends its contract with BCBSM.

Professional Provider Services – Continuity of Care

Coverage Requirements

We will pay temporary benefits for your continued treatment after a professional provider ends its participating contract with BCBSM as required by law.

These benefits are available for up to 90 days from the date the professional provider ends its contract with BCBSM if one of the following is true:

- You were undergoing a continued and regular course of treatment for a serious and complex condition by the provider;
- You are undergoing a course of institutional or inpatient care from the provider or facility;
- You are scheduled to undergo nonelective surgery from the provider or facility, including receiving postoperative care related to a surgery;
- You are pregnant and undergoing a course of treatment for the pregnancy from a provider; or
- You are terminally ill and receiving treatment for such illness from the provider.

Additionally, for continuity of care to apply, the following conditions must also be true:

- MESSA/BCBSM paid your claims for treatment of that condition before the professional provider ended the participating contract with BCBSM, and
- The services are medically necessary and would be covered if the professional provider was a BCBSM in-network or participating provider.

Payment for Continuity of Care Services

We will pay our approved amount for covered services, less your in-network cost-share, for up to 90 days to allow for a transition of care to an in-network provider. During this period, our paid amount less any required in-network cost share is considered as payment in full for continuity of care services.

Hospital or Facility Services

We pay temporary benefits for some services of noncontracted hospitals or facilities. These benefits are for continuity of care, designated services, emergency care, and travel and lodging. Benefits for continuity of care are available for up to six (6) months from the date the hospital or facility ends its participating contract with BCBSM. Benefits for designated services and emergency care are available for as long as they are medically necessary. Benefits for travel and lodging are available for the period of time approved by MESSA/BCBSM.

Mandatory Preapproval

You must obtain preapproval from BCBSM for any travel and lodging expenses before they occur. If you do not obtain preapproval, travel and lodging will not be covered and you will be responsible for these costs.

Continuity of Care

Coverage Requirements

We will pay for your continued treatment in a hospital or facility after it ends its participating contract with BCBSM as required by law. These benefits are available for up to six (6) months from the date the hospital or facility ends its contract with BCBSM if one of the following is true:

- You were undergoing a continued and regular course of treatment for a serious and complex condition by the provider or facility
- You are undergoing a course of institutional or inpatient care from the provider or facility
- You are scheduled to undergo nonelective surgery from the provider or facility, including receiving postoperative care related to a surgery
- You are pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- You are terminally ill and receiving treatment for such illness from the provider or facility

Additionally, for continuity of care to apply, the following conditions must also be true:

- BCBSM paid your claims for treatment of the same condition at the hospital or facility before it ended its participating contract with BCBSM, and
- The services are medically necessary and would be covered if the hospital or facility were a BCBSM in-network or participating hospital or facility.

Payment for Continuity of Care Services

We will pay our approved amount for covered services, less your in-network cost-share, for up to six months to allow for a transition of care to a participating hospital or facility. During this period, our paid amount less any required in-network cost share is considered as payment in full for continuity of care services.

Designated Services and Emergency Care

Coverage Requirements

We will pay for designated services and emergency care that you receive from a hospital or facility that ends its contract with BCBSM when the following criteria are met:

- The services are medically necessary and would be covered if the hospital or facility were a BCBSM in-network or participating hospital or facility, and
- The hospital or facility that ends its contract with BCBSM is within 75 miles of your primary residence (this applies only to designated services)

Payment for Designated Services and Emergency Care

When the above coverage requirements are met, we will pay you as follows:

- **Designated Services** – We will pay our approved amount, less your cost sharing. Our approved amount may be less than the bill. You may be required to pay the difference.
- **Emergency Care** – The below method is used to determine what we pay for accidental injuries and emergency services:
  - » We pay a rate based on the requirements of state or federal law
  - » The rate we pay for emergency care may be less than the bill; you will not be required to pay the difference between what the provider charges and what we pay (See ***Surprise Billing*** for more information).

    Note: You will not have to pay any out-of-network cost sharing that applies to these services. However, you must pay any in-network cost sharing that applies, which is calculated based on Michigan or federal law. The cost share you pay will apply to your in-network deductible and in-network out-of-pocket maximum. In some cases, cost sharing may be waived. See Section 2 for information about what cost sharing you must pay for accidental injuries and emergency services.

Transport from a Noncontracted Area Hospital or Facility

If you are receiving designated services or emergency care in a hospital or facility that ended its contract with BCBSM, and your physician says that you are medically stable, you may choose to be transferred to the nearest

participating hospital or facility that can treat your condition. We will pay our approved amount to transport you by ambulance to that hospital or facility.
If you use a nonparticipating ground ambulance service to transport you, the bill may be more than our approved amount. You may be required to pay the difference.
Note: If you transfer to a participating out-of-network hospital or facility, you do not have to pay any out-of-network cost sharing. But you will still have to pay for any in-network cost sharing.

MESSA/BCBSM will provide coverage for emergency services at nonparticipating hospitals or facilities until you are admitted and sign a form waiving your surprise billing protections. They provide you with no coverage if you are admitted on a nonemergency basis. If you decide to stay in a noncontracted hospital or facility and sign the form, we will pay you at the nonparticipating rate. Our rate may be less than the hospital or facility charges. You will have to pay the difference.

Limitations and Exclusions

- If you get services from a hospital or facility that ends its contract with BCBSM that are not designated services, we will pay only the amount we pay for nonparticipating hospital or facility services. You will have to pay the difference between what we pay and the hospital's or facility's charge. This difference may be substantial.
- We will pay for ambulance transport services only if they are for an admission that is covered under your plan. If your plan covers nonemergency transports, you will have to pay for your cost share.

Travel and Lodging

If you need to get services at an out-of-area hospital or facility, we will pay for the cost of travel and lodging if all the following are met:

- You live within 75 miles of the noncontracted area hospital or facility
- The travel and lodging are preapproved, and
- You cannot reasonably get covered services from:
  - A contracted hospital or facility in your area or other participating provider within 75 miles of the noncontracted area hospital or facility, and
  - Your physician directs you to an out-of-area hospital or facility.

Payment will be subject to the following provisions:

- **Inpatient Services** – If you need inpatient services from an out-of-area hospital or facility, we will pay a maximum of $250 per day for the reasonable and necessary cost of travel and lodging. We will pay up to a total of $5,000 for travel and lodging costs for each admission. Both of these maximum payment amounts will cover the combined expenses for you and the person(s) eligible to accompany you. If you spend less than $250 per day or a total of $5,000 for all of your travel and lodging, we will pay you the amount you actually spent. If you spend more than $250 per day or a total of $5,000, we will only pay you the maximum of $250 per day or $5,000 total for your travel and lodging expenses.

  Coverage will begin on the day before your admission and end on your date of discharge. We will pay for the following:

  - Travel for you and another person (two persons if the member is a child under the age of 18) to and from the out-of-area hospital or facility
  - Lodging for the person(s) eligible to accompany you

- **Outpatient Services** – If you need outpatient services from an out-of-area hospital, facility or physician, we will pay up to $125 for travel and lodging each time you need these services.

Limitations and Exclusions

- We do not pay for travel and lodging that were not preapproved.
- Travel and lodging will be paid only after you submit your original receipts to us.
- Travel does not include an ambulance transport to an out-of-area hospital or facility.
- We do not pay for travel and lodging beyond the maximums stated above.
- We will not pay for items that are not directly related to travel and lodging, such as:
  - Alcoholic beverages
  - Babysitters or daycare services
  - Books or magazines
  - Cable television
  - Car maintenance

- » Charges for hospital or facility services not covered, e.g., private room
- » Clothing
- » Dry cleaning
- » Flowers
- » Greeting cards
- » Household products
- » Household utilities (including cell phones)
- » Kennel fees
- » Laundry services
- » Maids
- » Movie rentals, private room
- » Security deposits
- » Stamps or stationery
- » Telephone
- » Television
- » Toiletries
- » Toys

- Any other services, admissions or length of stay related to any of the above exclusions
- The deductible, copayment or coinsurance requirements of your plan do not apply to travel and lodging.

Time Limit for Legal Action

Legal action against us may not begin later than three years after we have received a complete claim for services. No action or lawsuit may be started until 60 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

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
- Attempted suicide

Accelerated approval pathway

An FDA process that allows for earlier approval of certain drugs, including cellular and gene therapies, that have not yet demonstrated actual clinical benefit(s).

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 complex ongoing care and a wide range of medical, surgical, obstetrical or pediatric treatment. It generally requires a hospital stay of less than 30 days. Examples include chemotherapy, post-operative visits and radiation therapy.

Acute care facility

A facility that offers a wide range of medical, surgical, obstetric and pediatric services. These facilities primarily treat patients with conditions that 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.

Adverse benefit decision
A decision to deny, reduce or refuse to pay all or part of a benefit. It also includes a decision to terminate or cancel coverage.

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).

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, prescription 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 ACA.
- 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 ACA.

Athletic trainer
A healthcare professional who specializes in the practice of athletic training, clinical evaluation, injury and illness assessment, risk management, injury prevention, rehabilitation and reconditioning. Must be licensed by the state of Michigan and meet BCBSM qualification requirements. When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

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.

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 Services, if the commissioner determines that the diagnostic measure is recognized by the healthcare 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 MESSA/BCBSM to:

  - » Evaluate and diagnose the member as having one of the covered autism spectrum disorders and
  - » Determine whether ABA therapy is medically necessary and appropriate for members with autism spectrum disorders.

- **Autism spectrum disorders** – A developmental disability caused by differences in the brain. Autism spectrum disorder (ASD) is characterized by impaired social function, problems with verbal and nonverbal communication and imagination, and unusual or severely limited activities and interests. The treatment of ASD may be behavior modification.
- **Behavioral health treatment for autism** – 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.

Autism spectrum disorder services
Services that require a prior authorization for assessment, reassessment, and supervision of applied behavior analysis (ABA), line therapy, skills training, and caregiver training.

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.

Benefit period
The period of time that begins five days before, and ends one year after, the organ transplant. All payable human organ transplant services, except anti-rejection drugs and other transplant related prescription drugs, must be provided during this period of time.

Blue Cross Blue Shield Global Core Program
A program that provides access to a network of inpatient facilities and medical assistance services worldwide including referrals to professional providers for all BCBSM members whose claims are eligible for processing through the BlueCard Program.

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/BCBSM PPO members to receive healthcare 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.

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 MESSA/BCBSM qualification standards.
- When outside the state of Michigan, is legally qualified to perform services in the state where the services are performed.

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 MESSA/BCBSM 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 condition that recurs frequently or one that may or may not have been present at birth but will last a long time, perhaps throughout the patient's life. Therapy may not help and the chronic condition may eventually result in significant disability and/or death. Arthritis and heart disease are examples of chronic diseases. Disruption of the current course of treatment could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes.

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

Clinical licensed master's social worker
A clinical licensed master's social worker who provides some mental health services and who:

- Is licensed as a clinical social worker by the state of Michigan.
- Meets MESSA/BCBSM qualification standards.
- When outside of the state of Michigan, is legally qualified to perform services in the state where services are performed.

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.

Colonoscopy
A procedure for viewing the interior lining of the large intestine (colon) using a small camera called a colonoscope.

Continuity of care
Seamless, continuous care rendered by a specific provider that if interrupted, could have negative impacts on the specific condition or disorder for which the patient is being treated. Continuity of care also includes ongoing coordination of care in high-risk patients that have multiple medical conditions.

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

Contraceptive counseling
A preventive service that helps you choose a contraceptive method.

Contraceptive device
A device designed to prevent pregnancy. It may include a diaphragm, an intrauterine device or a contraceptive implant.

Contraceptive medication
Any drug used for the express purpose of preventing pregnancy at the time of its administration.

Contract
The insurance plan 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.

Coordination period
A period of time, defined by Medicare, that begins in the first month of Medicare entitlement due to ESRD and lasts for 30 months.

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 plan. 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 MESSA/BCBSM, to order or perform the service and must comply with MESSA/BCBSM 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.

Designated facility
To be a covered benefit, human organ transplants must take place in a "BCBSM-designated" facility. A designated facility is one that BCBSM determines to be qualified to perform a specific organ transplant. We have a list of designated facilities available for you and your physician upon request.

Designated services
Services that MESSA/BCBSM determines only a noncontracted area hospital is equipped to provide.

Detoxification
The medical process of removing an intoxicating or addictive substance from the body of a person who is dependent on that substance.

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.

Dual entitlement
When an individual is entitled to Medicare on the basis of both ESRD and age or disability.

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 MESSA.

Emergency care
Care to treat an accidental injury or medical emergency.

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 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 "investigational" or "experimental services."

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.

Gender affirming services
A collection of services that are used to treat the clinical diagnosis of gender dysphoria. These services may include hormone treatment and/or gender affirming surgery, as well as counseling and behavioral health services. These services must be medically necessary to be payable by MESSA/BCBSM. MESSA/BCBSM will not pay for services that it considers to be cosmetic. MESSA/BCBSM also will not pay for services that are experimental or investigational.

Gender dysphoria
A condition classified as emotional discomfort or distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth.

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.

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 healthcare 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 occupational therapist
An occupational therapist who provides some occupational therapy services and who:

- Is licensed as an occupational therapist by the state of Michigan
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed

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

In-network providers
Physicians or other healthcare professionals who have contracted to provide services to members enrolled in Essentials by MESSA and to accept the approved amount as payment in full. Prescription copayments, coinsurance and deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

Intensive outpatient program (IOP)
Treatment for mental, emotional and substance use disorders that consist of minimum of three hours per day, at least three days a week provided by a hospital or outpatient psychiatric care facility (OPC) to a member who lives at home and goes to a hospital or OPC.

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.

Life threatening
Disease or condition in which the likelihood of death is probable unless the course of the disease or condition in interrupted.

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

Mammogram
An imaging study of the breast using X-rays. The radiation machine must be state-authorized and specifically designed and used to perform mammography.

There are two types of mammograms:

- Screening mammograms assess members without any signs or symptoms to assist in the early identification of breast disease.
- Diagnostic mammograms assess members in whom signs and symptoms of breast disease are present.

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. Medically necessary means that according to evidence-based clinical practice guidelines (proven to be safe and effective based on current research), a healthcare service or procedure is considered necessary to treat, prevent or manage a disease. To meet medical necessity criteria, the following must be true:

- The services must be in accordance with generally accepted standards of medical practice; "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.
- The service, treatment, or supply is clinically appropriate for the symptoms and is consistent with the diagnosis; "Clinically appropriate" means the type, frequency, extent, site and duration are considered effective for the member's illness, injury or disease".
- The service is not mainly for the convenience of the member or healthcare provider.
- The treatment is not generally regarded as experimental by BCBSM.

There are two circumstances where this definition applies: payment of professional providers (M.D.s, D.O.s, podiatric physician, chiropractors, fully licensed psychologists and oral surgeons) and other providers services; and acute inpatient admissions and post-acute care admissions.

There are additional criteria for these two circumstances:

- Medical necessity for payment of professional providers and other providers services:
  - » 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.
- Medical necessity for payment of acute inpatient admissions and post-acute inpatient admissions:
  - » For inpatient hospital stays, the member's condition must necessitate acute care because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

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.

Newborn care
Hospital and professional services that are provided to newborns during the initial stay following birth. This care includes the newborn examination, which must be given by a physician other than the anesthesiologist or the birth parent's attending physician, and routine care during the newborn's inpatient stay.

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

Nonparticipating provider
Physicians or other healthcare professionals who have not signed a participation agreement with MESSA/

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 practitioner 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.

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

Out-of-network provider
Hospitals, physicians and other licensed facilities or healthcare professionals who have not contracted to provide services to members enrolled in Essentials by MESSA.

Outpatient mental health 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 use disorder treatment program
A program that provides medical and other services specifically for drug and alcohol abuse on an outpatient basis.

Partial hospitalization program (PHP)
Treatment for mental, emotional and substance use disorders for a minimum of four hours per day, at least five days a week provided by a hospital or an outpatient psychiatric care facility (OPC) to a member who lives at home and goes to a hospital or OPC. The American Association of Behavioral Health (AABH) recommends five to six hours a day for five to six days a week.

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. Prescription 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 healthcare professionals who have signed a participation agreement with BCBSM to accept the approved amount as payment in full. Prescription 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.

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 medicine
A branch of medicine that specializes in the diagnosis, treatment, and management of patients who have been disabled from a disease, condition, disorder, or injury. Services include but are not limited to:

- Manipulation
- Traction
- Massage
- Exercise
- Heat

Physical therapist
A therapist who provides some physical therapy services and who is licensed as a physical therapist by the state of Michigan.

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 doctor of medicine, osteopathy, podiatry, chiropractic or an oral surgeon. Physicians may also be referred to as "practitioners." The term physician or practitioner may also include other types of professional providers when they perform covered services within their scope of practice.

Physician assistant
A physician assistant is licensed by the state of Michigan to engage in the practice of medicine, osteopathic medicine and surgery, or podiatric medicine and surgery with a participating physician under a practice agreement.

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.

Post-service grievance
An appeal that you file when you disagree with our payment decision or our denial for a service that you have already received.

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, limited license psychologist, clinical licensed master's social worker, licensed professional counselor, licensed marriage and family therapist, 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 "in-network" provider.

Preferred provider organization (PPO)
A limited group of healthcare 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.

Pre-service grievance
An appeal that you can file when you disagree with our decision not to pre-approve a service you have not yet received.

Preventive care
Care designed to maintain health and prevent diseases or conditions at an early stage when treatment is likely to work best. Examples of preventive care include health screenings, mammograms, and colonoscopies.

Primary endpoint
The main outcome(s) the trial is designated to evaluate.

Primary payer
The healthcare coverage plan that pays first when you are provided benefits by more than one carrier.

Primary plan
The healthcare plan obligated to pay for services before any other healthcare plan that covers the member or patient.

Prior authorization
Some services and prescription drugs require prior authorization before you receive them. If you receive them without first obtaining prior authorization, the services may not be covered and you may have to pay the bill yourself.

Private duty nursing
Skilled nursing care provided in a patient's home. Services are provided on an hourly basis by a licensed nurse to individuals who require individualized and continuous 24-hour skilled nursing care. Services are ordered by the patient's attending physician and must meet the criteria for medical necessity.

Professional provider
This refers to one of the following:

- Doctor of medicine (M.D.)
- Doctor of osteopathy (D.O.)
- Podiatrist
- Chiropractor
- Physician assistant (PA)
- Fully licensed psychologist
- Independent physical therapist (IPT)
- Independent occupational therapist (IOT)
- Certified nurse midwife (CNM)
- Clinical licensed master's social worker (CLMSW)
- Licensed professional counselor (LPC)
- Oral surgeon
- Licensed behavior analyst
- Licensed marriage and family therapist (LMFT)
- Limited license psychologist (LLP)
- Independent speech therapist (IST)
- Certified nurse practitioner (CNP)
- Certified registered nurse anesthetist (CRNA)
- Other providers as identified by MESSA/BCBSM

NOTE: 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.

Psychiatric residential treatment facility
A facility that provides residents with 24-hour mental healthcare and treatment, seven days a week. The facility must participate with MESSA/BCBSM (if located in Michigan) or with its local Blue Cross/Blue Shield plan (if located outside of Michigan).

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.

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 they meet 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.

Rescission
The cancellation of coverage that dates back to the effective date of the member's contract and voids coverage during this time.

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 use disorder 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.

Right of recovery
Our right to make a claim against you, your dependents or representatives if you or they have received funds from another party responsible for benefits paid by us.

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.

Secondary plan
The healthcare plan obligated to pay for services after the primary plan has paid for services.

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 healthcare 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

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

Specialist
A provider with a specific skill or expertise in the treatment of a particular condition or disease.

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.

Spouse
An individual who is legally married to the subscriber and meets the group's eligibility requirements.

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 use disorder
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 use disorder is alcohol or drug abuse or dependence as classified in the most current edition of the "International Classification of Diseases." Tobacco addictions are also included in this definition

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.*

Telehealth
An umbrella term used to describe all the possible variations of healthcare services using telecommunications technology to support clinical healthcare.

Telemedicine
Real-time healthcare services, delivered via telephone, internet, or other electronic technology when you're not in your provider's presence. Telemedicine visits are for the purpose of treating an ongoing condition that is expected to result in multiple visits before the condition is resolved or stabilized. Contact for these services can be initiated by the member or provider and must be within your provider's scope of practice.

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.

Transplant benefit period
The period of time that begins five days before, and ends one year after, the organ transplant. All payable human organ transplant services, except anti-rejection drugs and other transplant–related prescription drugs, must be provided during this period of time.

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.

Virtual primary care
The ability for members 18 and over to access a virtual primary care provider by a secure HIPAA-compliant digital platform including messages, telephone and video calls. Virtual primary care is a convenient, virtual visit that provides a broad range of primary care services including management and coordination of a member's healthcare. BCBSM partners with a virtual primary care vendor to provide access to a virtual PCP.

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 MESSA or Blue Cross Blue Shield of Michigan.

Well-baby care
Services provided in a physician's office to monitor the health and growth of a healthy child.

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

We Speak Your Language

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 800-336-0013, TTY: 888-445-5614 or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se ofrecen, sin costo alguno, ayuda y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 800-336-0013, TTY: 888-445-5614 o hable con su proveedor.

تنبيه: إذا كنت تتحدث الإنجليزية، فإن خدمات المساعدة اللغوية المجانية متوفرة لك. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل برقم 800-336-0013, TTY: 888-445-5614 أو تحدث إلى مزود الخدمة الخاص بك.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。请致电 800-336-0013, TTY: 888-445-5614 或咨询您的服务提供商。

ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܚܕ̈ܡܬܐ ܕܡܥܕܪܢܘܬܐ ܕܠܫܢܐ ܒܡܓܢܐ ܦܝܫܐ ܩܛܝܒܐ ܩܐ ܚܘܟܘܢ. ܐܦ ܚܕ̈ܡܬܐ ܘܡܥܕܪܢܘܬܐ ܠܡܬܠ ܡܘܕܥܢܘܬܐ ܒܕܘܟܬܐ ܕܡܨܝܬܘܢ ܠܡܛܝܐ ܠܗ̇ ܦܝܫܐ ܩܐ ܚܘܟܘܢ. ܡܩܪܘܢ ܥܠ ܡܢܝܢܐ 800-336-0013, TTY: 888-445-5614 ܝܢ ܡܗܡܙܡܘܢ ܥܡ ܡܗܝܡܢܘܬܟܘܢ.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ và dịch vụ phù hợp để cung cấp thông tin bằng các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi số 800-336-0013, TTY: 888-445-5614 hoặc trao đổi với người cung cấp dịch vụ của bạn.

VËMENDJE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 800-336-0013, TTY: 888-445-5614 ose bisedoni me ofruesin tuaj të shërbimit.

알림: 한국어를 사용하는 경우 언어 지원 서비스를 무료로 이용할 수 있습니다. 정보를 접근 가능한 형식으로 제공받을 수 있는 적절한 보조 기구와 서비스도 무료로 이용할 수 있습니다. 800-336-0013, TTY: 888-445-5614 번으로 전화하거나 담당 기관에 문의하십시오.

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 800-336-0013, TTY: 888-445-5614 নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 800-336-0013, TTY: 888-445-5614 lub porozmawiaj ze swoim usługodawcą.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 800-336-0013, TTY: 888-445-5614 an oder sprechen Sie mit Ihrem Provider.

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'800-336-0013, TTY: 888-445-5614 o parla con il tuo fornitore.

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。情報をアクセスしやすい形式で提供するための適切な補助器具やサービスも無料でご利用いただけます。800-336-0013, TTY: 888-445-5614 までお電話いただくか、ご利用の事業者にご相談ください。

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 800-336-0013, TTY: 888-445-5614 или обратитесь к своему поставщику услуг.

PAŽNJA: Ako govorite srpsko-hrvatski, dostupne su vam besplatne usluge jezične pomoći. Odgovarajuća pomoćna pomagala i usluge za pružanje informacija u pristupačnim formatima također su dostupni besplatno. Nazovite 800-336-0013, TTY: 888-445-5614 ili razgovarajte sa svojim pružateljem usluga.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na karagdagang tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 800-336-0013, TTY: 888-445-5614 o makipag-usap sa iyong provider.

Discrimination Is Against The Law

MESSA, Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). MESSA, Blue Cross Blue Shield of Michigan and Blue Care Network does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

MESSA, Blue Cross Blue Shield of Michigan and Blue Care Network:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provide free language services to people whose primary language is not English, which may include qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 800-336-0013, TTY: 888-445-5614. Here's how you can file a civil right complaint if you believe that MESSA, Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide these 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, by mail, fax, or email with:

MESSA General Counsel
P.O. Box 2560, East Lansing, MI 48826-2560
Phone: 800-292-4910, TTY: 888-445-5613, Fax: 517-203-2909
Email: **CivilRights-GeneralCounsel@messa.org**

If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal website or by mail, phone, or email at:

U.S. Department of Health & Human Services
200 Independence Ave, SW, Room 509, HHH Building, Washington, D.C. 20201
Phone: 800-368-1019, TTD: 800-537-7697
Email: **OCRComplaint@hhs.gov**

Complaint forms are available on the U.S. Department of Health & Human Services Office for Civil Rights website.

This notice is available at MESSA's website:

https://www.messa.org/pdf/MESSA Non-Discrimination Policy.pdf

LAC | Rev. 10/03/24

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LAC | Rev. 08/04/26