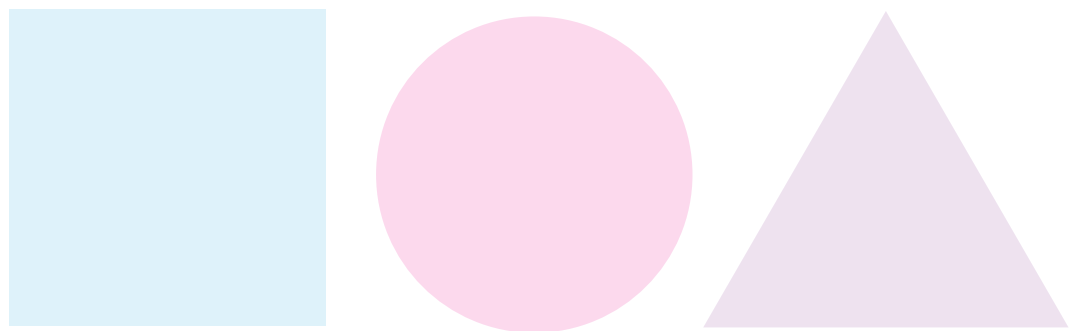




Medical plan coverage



800.336.0013 • TTY: 888.445.5614

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Essentials by MESSA – Helpful information

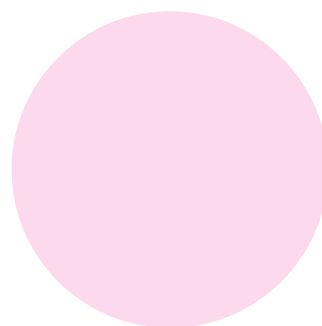
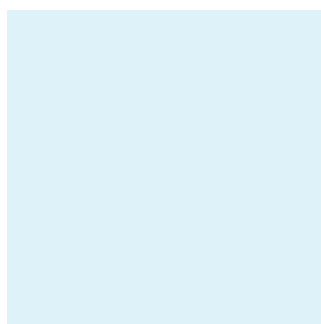
Health care benefits provided under the Essentials by MESSA Preferred Provider Organization (PPO) plan are underwritten by Blue Cross Blue Shield of Michigan (BCBSM) and 4 Ever Life.

This booklet is designed to help you understand your coverage.

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

Occasionally, state or federal law requires changes to medical coverage. When such changes occur, this booklet will be revised and posted at messa.org.

This document is not a contract. It is intended to be a summary description of benefits. Every effort has been made to ensure the accuracy of this information. However, if statements in this description differ from the applicable coverage documents, then the terms and conditions of those documents will prevail.



How to contact us

Give us a call

MESSA Member Service Center – 800.336.0013 or
TTY 888.445.5614

Let's talk in person

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

Let us call you

Log in to your member account at [messa.org](https://www.messa.org) and send us a secure message if you'd like a MESSA team member to contact you.

By mail

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

Tips to help us serve you better

Here are some important tips to remember:

1. Have your ID card handy so you can provide your enrollee ID/contract number. If you are writing to us, include this information in your correspondence.
2. To ask if a particular service is covered, please have your physician provide you with the five-digit procedure code. If your planned procedure does not have a code, obtain a complete description of the service as well as the diagnosis.

NOTE: Benefits cannot be guaranteed over the phone.

3. To inquire about a claim, please provide the following:
 - > Patient's name
 - > Provider's name (such as the doctor, hospital or supplier)
 - > Date the patient was treated
 - > Type of service (for example, an office visit)
 - > Charge for the service
4. When writing to us, please send copies of your bills, other relevant documents, and any correspondence you have received from us. Make sure you keep your originals.
5. Include your daytime telephone number as well as your enrollee ID/contract number on all correspondence.

Your ID card

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

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

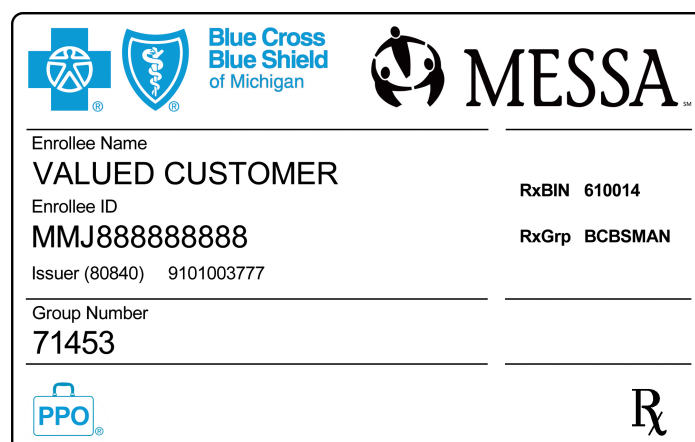
- **Enrollee name** is the name of the person who holds the contract.
- **Enrollee ID** identifies your records in our files. The **alpha prefix** preceding the enrollee ID number identifies that you have coverage through MESSA.
- **Issuer** identifies you as a Blue Cross Blue Shield of Michigan member. The number 80840 identifies the industry as a health insurance carrier.
- **Group number** tells us you are a MESSA/BCBSM group member.

The suitcase tells providers about your travel benefits.

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

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

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



Here are some tips about your ID card:

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

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

Explanation of Benefit (EOB) statements

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

An EOB includes:

- Member name.
- Family member who received services.
- Contract number (enrollee ID).
- Claim number.
- Date of service.
- Type of service.
- 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, please contact your provider first. If they cannot correct the error, call the MESSA Member Service Center.

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

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

Eligibility guidelines

Who is eligible for coverage?

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

- Any member of the Michigan Education Association (MEA) as defined in 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 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.

- Your 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 becomes eligible for premium subsidies.

It is your responsibility to notify MESSA and your employer:

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

During your active employment, special health care 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 he/she becomes 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 he/she becomes 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 us or another party which results in you or a dependent obtaining or retaining coverage with MESSA or the payment of claims under this or another MESSA plan. You will be provided with prior notice of the rescission, if required under the law. You will be required to repay us for our payment for any services you received during this period.
- **Member no longer eligible** – Coverage will end on the last day of the month in which a member no longer meets the eligibility criteria described in this section.
- **Dependent no longer eligible** – Coverage will end on the date a dependent no longer meets the eligibility criteria described in this section.
- **Termination of the MESSA/BCBSM group agreement** – Coverage will end on the date the Group Agreement terminates.
- **Member's Attainment of Age 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 his/her 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 Health Care Coverage." Contact MESSA for additional information.

Continuation of health care 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 the 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, unless that new health plan has preexisting condition limitations that apply to the qualified beneficiary.

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 health care 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) provider 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 that 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 that 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 percent of Michigan physicians are in the network. PPO networks save you money because those hospitals and doctors agree to accept discounted fees. This also helps your group save on its premiums.

We offer the largest network of doctors, hospitals and other health care 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:

1. Ask your doctor or other medical provider if he or she is in the BCBSM network.
2. Go to [messa.org](https://www.messa.org) to use our “Find a doctor” feature.
3. Call MESSA at 800.336.0013 or TTY 888.445.5614.

Out-of-network providers

When you receive care from a provider who is not part of the PPO network, without a referral from a PPO provider, your care is considered out-of-network. For most out-of-network services, you have higher deductibles and coinsurance. Out-of-network expenses 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.

Services received at nonparticipating facilities are not covered unless for emergency services.

Changes in provider classification

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

Providers may also choose to terminate their participation agreements with BCBSM. **If a facility terminates its participation, services at the facility will no longer be**

covered unless the benefits are for emergency services, designated services or continuity of care. For more information on these benefits, see the hospital care 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

Services received at non-participating facilities are not covered unless for emergency services.

Emergency hospital admissions

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

Requesting additional days

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

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

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

Appealing a nonapproved admission or extension

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

Receiving services without prior approval

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

You have access to personal support from a MESSA nurse

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

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

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

Each of the programs provide members and their dependents with:

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

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

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/BCBSM ID card on you.

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

For urgent care that requires attention within 48 hours:

All urgent care is covered, no matter where you are. Just make sure you have your MESSA/BCBSM ID card with you. Call 800.336.0013 or TTY 888.445.5614 or visit www.messa.org to find a doctor or hospital.

For non-emergency care:

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

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

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

Medical care while traveling outside the U.S.

You have access to doctors and hospitals with the 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 BCBSM ID 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 1.800.810.2583 (or call collect at 1.804.673.1177). They can direct you to the nearest medical facility.

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

For non-emergency care:

Call Blue Cross Blue Shield Global Core at 1.800.810.2583 to find a hospital or authorized health care provider. You may have to pay for all costs upfront. You can submit a claims reimbursement form and send it with any itemized bills to MESSA for review.

Contacting MESSA from outside the U.S.

From the U.S. Virgin Islands, Puerto Rico, Canada and Guam: 1.800.380.3251.

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

Don't forget your medications

When you're traveling, knowing you have access to medication when you need it is always a great relief. Make sure you have enough prescription medication to last until you return.

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

Deductibles

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

There 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.

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.

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.

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
<ul style="list-style-type: none"> - Deductible - Copayment may apply - Coinsurance may apply after deductible is met 	<ul style="list-style-type: none"> - Deductible - Coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
<p><i>For your plan's specific benefit levels, log in to your member account at messa.org.</i></p>		

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 radiotherapy treatments.
- Injections of anti-allergen, antihistamine, bronchodilator or antispasmodic agents.

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

Ambulance

What you pay for covered services	
There is currently no network; in-network (IN) benefits apply	
Participating provider	Nonparticipating provider
<ul style="list-style-type: none"> - IN deductible - IN coinsurance may apply after deductible is met 	<ul style="list-style-type: none"> - IN deductible - IN coinsurance may apply after deductible is met - Charges in excess of approved amount
<p><i>For your plan's specific benefit levels, log in to your member account at messa.org.</i></p>	

Covered services include transportation by professional 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
<ul style="list-style-type: none"> - Deductible - Coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - Deductible - Coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
<p><i>For your plan's specific benefit levels, log in to your member account at messa.org.</i></p>		

Anesthesia continued on next page.

Anesthesia continued...

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

- A physician, other than the physician performing the service.
- A physician who orders and supervises anesthesiologist services.
- A certified registered nurse anesthetist (CRNA) in an:

- > Inpatient hospital setting.
- > Outpatient hospital setting.
- > Participating ambulatory surgery facility.

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

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

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

What you pay for covered services	
There is currently no network; in-network (IN) benefits apply	
Participating provider	Nonparticipating provider
<ul style="list-style-type: none"> - IN deductible - Copayment may apply - IN coinsurance may apply after deductible is met 	<ul style="list-style-type: none"> - IN deductible - Copayment may apply - IN coinsurance may apply after deductible is met - Charges in excess of approved amount
<i>For your plan’s specific benefit levels, log in to your member account at messa.org.</i>	

Autism Spectrum Disorders – Rendered by PhD

What you pay for covered services		
In-network (IN)	Out-of-network (OON)	Nonparticipating provider
<ul style="list-style-type: none"> - Deductible - Copayment may apply - Coinsurance may apply after deductible is met 	<ul style="list-style-type: none"> - Deductible - Coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
<i>For your plan’s specific benefit levels, log in to your member account at messa.org.</i>		

Applied Behavior Analysis services

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

Prior authorization of ABA services is required. If prior authorization is not obtained, the member will be responsible for 100% of the cost of treatment. A member seeking ABA services is required to go to a BCBSM-Approved Autism Evaluation Center (AAEC) for the evaluation, diagnosis and/or confirmation of a diagnosis of an ASD and have a high level treatment plan developed. If ABA services are recommended

by the AAEC, the member can seek services from a Board-Certified Behavior Analyst (BCBA), who will then develop a detailed treatment plan specific to ABA treatment. The BCBA **must** obtain prior approval from BCBSM, otherwise the member will be responsible for the cost of treatment.

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

- A Board-Certified Behavior Analyst registered with BCBSM (all BCBA’s registered with BCBSM are considered in-network), or

Autism Spectrum Disorders – Rendered by PhD continued...

- a fully licensed psychologist, so long as the services performed are commensurate with the psychologist’s formal university training and supervised experience

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.

Additional covered services

Additional covered services for ASD include:

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

Services and conditions not covered

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

Definitions for autism-related services can be found in the [Glossary of Health Care Terms](#) of this booklet.

Bone marrow transplants*

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

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

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

- Allogeneic transplants
- Autologous transplants

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

Bone marrow transplant — covered conditions

Allogeneic transplants are covered to treat:

- Acute lymphocytic leukemia (high-risk, refractory or relapsed patients).
- Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients).
- Acute myelogenous leukemia (high-risk, refractory or relapsed patients).
- Aplastic anemia (acquired or congenital, e.g., Fanconi’s anemia or Diamond-Black fan syndrome).
- Beta-thalassemia.
- Chronic myeloid leukemia.
- Hodgkin’s disease (high-risk, refractory or relapsed patients).
- Myelodysplastic syndromes.

Bone marrow transplant — covered conditions continued...

- 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.
- Mucopolysaccharidoses (e.g., Gaucher's disease, metachromatic leukodystrophy, globoid cell leukodystrophy, adrenoleukodystrophy) for patients who have failed conventional therapy (e.g., diet, enzyme replacement) and who are neurologically intact.

- Renal cell CA.
- Plasmacytomas.
- Other conditions for which treatment is non-experimental.

Autologous transplants are covered to treat:

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

Bone marrow transplant — covered services & exclusions

Allogeneic transplants

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

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

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

Autologous transplants

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

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

We do not pay for:

- Services rendered to a transplant recipient who is not a MESSA member.
- Services rendered to a donor when the donor's health care coverage will pay.
- Services rendered to a donor when the transplant recipient is not a MESSA member.
- Expenses related to travel or lodging for the donor or recipient.
- 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.

Certified nurse midwife services – see [Maternity care](#)

Chemotherapy

What you pay for covered services		
In-network (IN)	Out-of-network (OON)	Nonparticipating provider
<ul style="list-style-type: none"> - Deductible - Coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - Deductible - Coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
<p><i>For your plan's specific benefit levels, log in to your member account at messa.org.</i></p>		

We pay for chemotherapeutic drugs that are:

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

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

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

We also pay for:

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

Chiropractic services– see [Spinal manipulations](#)

Colonoscopy – Preventive

What you pay for covered services		
In-network (IN)	Out-of-network (OON)	Nonparticipating provider
- No cost to you	- Not covered	- Not covered

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

Colonoscopy – Medically necessary

What you pay for covered services		
In-network (IN)	Out-of-network (OON)	Nonparticipating provider
- Deductible - Coinsurance 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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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.
- Traumatic scars.

NOTE: 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
<ul style="list-style-type: none"> - IN deductible - IN coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - 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 member account at messa.org .	

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

- Accidental injury to sound natural teeth.
- The removal of cysts and tumors of the mouth and jaw.

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

Diagnostic services

What you pay for covered services		
In-network (IN)	Out-of-network (OON)	Nonparticipating provider
<ul style="list-style-type: none"> - Deductible - Coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - Deductible - Coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - 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 member account at messa.org .		

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

- Thyroid function.
- Electrocardiogram.
- Electroencephalogram.

- Electromyogram.
- Nerve conduction.
- Pulmonary function studies.

The services must be prescribed by a physician.

Diagnostic laboratory and pathology services

What you pay for covered services		
In-network (IN)	Out-of-network (OON)	Nonparticipating provider
<ul style="list-style-type: none"> - Deductible - Coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - Deductible - Coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - 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 member account at messa.org .		

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

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

Durable Medical Equipment (DME)

What you pay for covered services	
There is currently no network; in-network (IN) benefits apply	
Participating provider	Nonparticipating provider
<ul style="list-style-type: none"> - IN deductible - IN coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - 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 member account at messa.org .	

Covered services include the rental cost, not to exceed the purchase price, of durable medical equipment when prescribed by a physician and purchased from a payable DME provider. Call MESSA at 800.336.0013 for more information.

Emergency room (ER)

– Facility charges

What you pay for covered services		
In-network (IN)	Out-of-network (OON)	Nonparticipating provider
<ul style="list-style-type: none"> - Deductible - ER copayment 	<ul style="list-style-type: none"> - IN deductible - ER copayment 	<ul style="list-style-type: none"> - IN deductible - ER copayment - Charges in excess of approved amount
For your plan's specific benefit levels, log in to your member account at messa.org .		

– Physician charges

What you pay for covered services		
In-network (IN)	Out-of-network (OON)	Nonparticipating provider
<ul style="list-style-type: none"> - Deductible 	<ul style="list-style-type: none"> - IN deductible 	<ul style="list-style-type: none"> - IN deductible - Charges in excess of approved amount
For your plan's specific benefit levels, log in to your member 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.

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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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

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

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

Hearing care services – 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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>	

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

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

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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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

Home health care

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

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

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

Covered services include:

- Part-time skilled nursing care (full-time care is not covered) rendered by a registered nurse or a licensed practical nurse.

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

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

Hospice care

What you pay for covered services	
There is currently no network; in-network (IN) benefits apply	
Participating provider	Nonparticipating provider
- No cost to you	- Charges in excess of approved amount

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

Benefits become available when:

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

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

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

First 90-day period

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

Second 90-day period

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

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

Third 90-day period

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

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

Fourth 90-day period

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

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

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

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

Payable services

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

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

- Inpatient care provided by a hospice inpatient unit, hospital or skilled nursing facility contracting with the hospice program

Hospice care continued...

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

Hospital care

– Facility charges

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 except in extraordinary circumstances . Contact MESSA Member Services for more information.
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

– Physician charges

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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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

Benefit period

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

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

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

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.

Human organ transplants continued...

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

Human organ transplants (kidney, cornea and skin)

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

Services for kidney, 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 – 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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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

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

Mammography – Medically necessary

What you pay for covered services		
In-network (IN)	Out-of-network (OON)	Nonparticipating provider
- Deductible - Coinsurance 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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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

Maternity care – Delivery, ultrasounds and certain labs

What you pay for covered services		
In-network (IN)	Out-of-network (OON)	Nonparticipating provider
- Deductible - Coinsurance 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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

Maternity care – Prenatal and postnatal

What you pay for covered services		
In-network (IN)	Out-of-network (OON)	Nonparticipating provider
- No cost to you	- Deductible - Coinsurance applies after deductible is met	- OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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

Medical Case Management (MCM) claims

What you pay for covered services		
In-network (IN)	Out-of-network (OON)	Nonparticipating provider
- Deductible - Coinsurance 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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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

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

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

- Pancreatitis
- Major head trauma
- Spinal cord injury
- Amputations
- Multiple fractures

- Severe burns
- Neonatal high-risk infants
- Severe stroke
- Multiple sclerosis
- Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- Acquired immune deficiency syndrome (AIDS)
- Crohn's disease
- Cancer

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

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

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

Medical supplies

What you pay for covered services	
There is currently no network; in-network (IN) benefits apply	
Participating provider	Nonparticipating provider
<ul style="list-style-type: none"> - IN deductible - IN coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - 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 member account at messa.org .	

We pay for many medical supplies and dressings when ordered by a physician for the treatment of a specific medical condition (e.g., test strips and lancets for the treatment of diabetes). 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.

Mental health and substance use disorder services

– Facility charges*

What you pay for covered services		
In-network (IN)	Out-of-network (OON)	Nonparticipating provider
<ul style="list-style-type: none"> - Deductible - Copayment may apply - Coinsurance may apply after deductible is met 	<ul style="list-style-type: none"> - Deductible - Coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - Not covered except in extraordinary circumstances. Contact MESSA Member Services for more information.
For your plan's specific benefit levels, log in to your member account at messa.org .		

***Preapproval 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. For more information regarding these services, see the hospital care section.

We pay for medically appropriate 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. Mental health and substance use disorder services must be medically necessary and provided by an eligible provider.

– Physician charges

What you pay for covered services		
In-network (IN)	Out-of-network (OON)	Nonparticipating provider
<ul style="list-style-type: none"> - Deductible - Copayment may apply - Coinsurance may apply after deductible is met 	<ul style="list-style-type: none"> - Deductible - Coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - 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 member account at messa.org .		

We pay for medically appropriate 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. Mental health and substance use disorder services must be medically necessary and provided by an eligible provider.

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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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

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

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

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

Oncology clinical trials continued...

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.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the trial participant.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Harvesting and storage costs of bone marrow, umbilical cord blood and/or peripheral blood stem cells if not intended for transplant within one year.
- Services for a transplant recipient who is not a MESSA member.
- Services rendered to a donor when the transplant recipient is not a MESSA member.
- Services rendered to a donor when the donor's health care coverage will pay.

Oncology clinical trials continued...

- Non-health care related services and/or research management (such as administrative costs).
- Search of an international donor registry
- Items that are not considered directly related to travel and lodging (examples include, but are not limited to the following: mortgage, rent payments, furniture rental, dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, cash advances, lost wages, tips, toys, household products, alcoholic beverages, flowers, greeting cards, stationery, stamps, gifts, household utilities (including cellular telephones), maids, babysitter or day care services, services provided by family members, reimbursement of food stamps, mail or UPS services, internet connection and entertainment (such as cable television, books, magazines and movie rentals).
- Any facility, physician or associated services related to any of the above named exclusions.

Osteopathic manipulations — 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 adult immunizations are covered at participating pharmacies. Call MESSA for additional information.

Private duty nursing*

What you pay for covered services	
There is currently no network; in-network (IN) benefits apply	
Participating provider	Nonparticipating provider
<ul style="list-style-type: none"> - IN deductible - IN coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - IN deductible - IN coinsurance applies after deductible is met - Charges in excess of approved amount
<p><i>For your plan's specific benefit levels, log in to your member account at messa.org.</i></p>	

***Preapproval 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 if it is:

- Skilled care given by a professional registered nurse or licensed practical nurse (requiring, for example: administration of I.V. drugs, ventilator care, etc.).
- Medically necessary and required on a 24-hour basis.

- Given in a hospital, because the hospital lacks intensive or cardiac care units or has no space in such units.
- Provided by a nurse who is not related to or living with the patient.

All progress notes must be submitted with the claim form.

Prosthetic and orthotic devices

What you pay for covered services	
There is currently no network; in-network (IN) benefits apply	
Participating provider	Nonparticipating provider
<ul style="list-style-type: none"> - IN deductible - IN coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - IN deductible - IN coinsurance applies after deductible is met - Charges in excess of approved amount
<p><i>For your plan's specific benefit levels, log in to your member account at messa.org.</i></p>	

We pay for prosthetic and orthotic devices when required because you do not have a certain body part or the device would improve your body's function. Devices must be prescribed by a physician. Repairs or replacements are covered due to wear and tear or growth. 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.
- Orthopedic shoes meeting MESSA guidelines.
- One pair of prescription eyeglasses or contact lenses if you do not have an organic lens or following cataract surgery or accidental injury while covered by this plan.
- Prefabricated custom-made orthotic devices.
- External cardiac pacemakers.
- Maxillofacial prosthesis when approved; these devices may be provided by dentists.

Psychiatric residential treatment*

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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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

We pay for the following:

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

Limitations and exclusions

We do not pay for:

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

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

Radiology services*

What you pay for covered services		
In-network (IN)	Out-of-network (OON)	Nonparticipating provider
<ul style="list-style-type: none"> - Deductible - Coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - Deductible - Coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
<p><i>For your plan's specific benefit levels, log in to your member account at messa.org.</i></p>		

***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).

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
<ul style="list-style-type: none"> - IN deductible - IN coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - Not covered
<p><i>For your plan's specific benefit levels, log in to your member account at messa.org.</i></p>	

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

Speech Therapy – see [Therapy services](#)

Spinal manipulations

What you pay for covered services		
In-network (IN)	Out-of-network (OON)	Nonparticipating provider
<ul style="list-style-type: none"> - Deductible - Copayment applies - Coinsurance may apply after deductible is met 	<ul style="list-style-type: none"> - Deductible - Coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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
<ul style="list-style-type: none"> - Deductible - Coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - Deductible - Coinsurance applies after deductible is met 	<ul style="list-style-type: none"> - OON deductible - OON coinsurance applies after deductible is met - Charges in excess of approved amount
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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, alveoplasty 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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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

We do not pay for technical surgical assistance:

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

Therapy services

What you pay for covered services		
In-network (IN)	Out-of-network (OON)	Nonparticipating provider
- Deductible - Coinsurance 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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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.

Therapy services continued...

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
<i>For your plan’s specific benefit levels, log in to your member account at messa.org.</i>		

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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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
<i>For your plan's specific benefit levels, log in to your member account at messa.org.</i>		

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.
 - Charges incurred because of war, declared or undeclared, or any act thereof.
 - Injury or sickness sustained or contracted in the armed forces or any country.
 - 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. In addition, we do not pay for administrative costs related to experimental treatment or for research management.
 - Eye examinations and eyeglasses or other corrective visual appliances except as specified elsewhere in this booklet.
 - Inpatient hospital confinement for the sole testing for, or detoxification of, allergy or allergy-related conditions.
 - Items for the personal comfort or convenience of the patient.
 - Reversal of sterilization procedures and related services.
 - Routine health examinations and related services or routine screening procedures (except as previously specified in the Preventive Care Services section).
 - Services, supplies or treatment provided by an immediate relative or by anyone who customarily lives in the member's household.

Exclusions and limitations continued...

- 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 reassignment services that are considered by MESSA/BCBSM to be cosmetic, or treatment that is experimental or investigational.
- Health care 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.
- 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.
- Conditions such as Rett's Disorder and Childhood Disintegrative Disorder.
- Any treatment that is not a covered benefit by us, including but not limited to, sensory integration therapy and chelation therapy.
- Therapeutic massage performed by a massage therapist.
- Bariatric surgery.
- Acupuncture.
- Hearing aids.
- Services performed by an ACSW.
- Services performed by a registered dietitian.
- Weight loss programs, 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.*

How to file a medical claim

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

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

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

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

3. Mail the claim form and itemized statement to:

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

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

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

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

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

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

You may also use the Find a Doctor link 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:

Associate Manager, Legal and Compliance
MESSA
1475 Kendale Boulevard
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 or 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.



Grievance process continued...

NOTE: 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.

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:

Associate Manager, Legal and Compliance
 MESSA
 1475 Kendale Boulevard, 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:

Associate Manager, Legal and Compliance
 MESSA
 1475 Kendale Boulevard, 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 MESSA/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.



Grievance process continued...

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 listed below. Mail your request and the required forms that we give you to:

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

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, the department 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 the department 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

The department 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 the department 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 the department.

The review group will recommend within 14 days whether the department should uphold or reverse our decision. The department 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, department staff will recommend whether our determination should be upheld or reversed.

The department 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 the Michigan Department of Insurance and Financial Services.

Grievance process continued...

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

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.

- The department will decide if your request qualifies for an expedited review. If it does, the department will assign an independent review group to conduct the review. The group will recommend within 36 hours if the department should uphold or reverse our decision.

- The department must decide whether to accept the recommendation within 24 hours. You will be told of the department's 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 health care plan if our decision was based on your benefits. If our decision was based on medical guidelines, we will provide you with the appropriate protocols and treatment criteria. If we involved a medical expert in making this decision, we will provide that person's credentials.

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

Other resources to help you

For questions about your rights, this notice, or for assistance, you can contact the 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; or
- 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.

Contest

If you seek payment for a denied claim, MESSA will furnish you with specific reason(s) for the denial, as well as any additional information required. If you ask us to reconsider the claim under our claim review procedure and we maintain our denial, you must wait 30 days before bringing any legal action against us. If the claim is two years old or more, you cannot bring any legal action against us.

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.

Determination of medical necessity

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

Subrogation: 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.

Other general information continued...

- 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.

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.

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 of health care terms

Accidental injury

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

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

Accredited hospital

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

Acute care

Medical care that requires 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 which require a hospital stay of less than 30 days. The facility is not used primarily for:

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

Administrative costs (approved oncology trials)

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

Allogeneic (Allogenic) bone marrow transplant

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

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.

Glossary of health care terms

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 Patient Protection and Affordable Care Act (PPACA).
- A trial conducted under an investigational new drug application reviewed by the FDA.
- A drug trial that is exempt from having an investigational new drug application.
- A study or investigation conducted by a federal department that meets the requirements of Section 2709 of the PPACA.

Attending physician

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

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

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

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.

Glossary of health care terms

Autism

- Autism diagnostic observation schedule

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

- Autism evaluation center

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

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

- Autism spectrum disorders

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

- Behavioral health treatment

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

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

- Line therapy

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

- Board certified behavior analyst

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

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

Glossary of health care terms

Autism continued

- Autism evaluation

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

- Autism prior authorization process

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

- Autism treatment plan

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

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

There are two levels to the treatment plan:

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

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.

Glossary of health care terms

Blue Cross plan

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

Blue Shield plan

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

BlueCard PPO program

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

Certified nurse midwife

A nurse who provides some maternity services and who:

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

Certified nurse practitioner

A nurse who provides some medical services and who:

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

Certified registered nurse anesthetist

A nurse who provides anesthesiology services and who:

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

Glossary of health care terms

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 trial

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

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

Coinsurance

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

Contraception

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

Contract

The insurance 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.

Copayment

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

Glossary of health care terms

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 us, to order or perform the service and must comply with our policies when rendering the service.

Custodial care

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

Deductible

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

Dental care

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

Designated cancer center

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

Developmental condition

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

Dialysis

Removal of toxic substance(s) from the blood.

Direct supervision

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

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.

Glossary of health care terms

Effective date

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

Emergency medical condition

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

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

Emergency services

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

End stage renal disease

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

Exclusions

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

Experimental or investigational treatment

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

Glossary of health care terms

Extraordinary nonparticipating provider coverage

Contact MESSA Member Services for more information. If a facility cancels its contract with BCBSM and terminates participation, services are payable only in the following extraordinary circumstances:

1) Emergency services

- Care to treat an accidental injury or medical emergency.

2) Designated services

- Unique services that are not available at a participating facility within a 75-mile radius of the non-participating facility.
- Preapproval is mandatory for designated services.

3) Continuity of Care

- Treatment provided in situations for which a disruption of the current course of treatment could cause a recurrence or worsening of the condition and interfere with anticipated outcomes. Available in the following circumstances:

Maternity care

- Member must be in the second or third trimester at the time of contract termination.
- Care is available up to six weeks following delivery.

Terminal illness

- Requires diagnosis prior to the date of contract termination.
- Care may continue for the remainder of the member's life if it is directly related to the diagnosis.

Life threatening, acute or chronic condition

- Requires an ongoing course of treatment in which the member was treated at least twice in the past 12 months.
- Care may continue through the course of treatment or for 90 days following notice to the member from the provider that participation with BCBSM has been terminated, whichever period is shorter.
- Requires regular visits with the provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol.
- Does NOT include monitoring services for a stable chronic condition such as poorly controlled diabetes or frequently managed asthmatic care.

Glossary of health care terms

Facility

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

First degree relative

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

First priority security interest

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

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

This right may be invoked without regard for:

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

Food and Drug Administration (FDA)

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

Freestanding outpatient physical therapy facility

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

Gynecological examination

A history and physical examination of the female genital tract.

Health maintenance examination

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

High-dose chemotherapy

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

Glossary of health care terms

High-risk patient

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

HLA genetic markers

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

Home health care agency

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

Hospice

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

Hospital

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

Host plan

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

Independent physical therapist

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

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

Glossary of health care terms

In-network providers

Physicians or other health care professionals who have contracted to provide services to members enrolled in 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.

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 is interrupted.

Lobar lung

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

Maternity care

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

Maxillofacial prosthesis

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

Medical emergency

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

Medically necessary

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

Medical necessity for payment of professional provider services:

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

- In accordance with generally accepted standards of medical practice;

Glossary of health care terms

Medically necessary continued

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

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

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

Medical necessity for payment of hospital and LTACH services:

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

Medical necessity for payment of services of other providers:

- Determination by physicians acting for us, based on criteria and guidelines developed by physicians for us who are acting for their respective provider type or medical specialty, that:
 - > The covered service is accepted as necessary and appropriate for the patient's condition. It is not mainly for the convenience of the member or physician.
 - > In the case of diagnostic testing, the results are essential to and are used in the diagnosis or management of the patient's condition.

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

Glossary of health care terms

Member

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

MESSA

Michigan Education Special Services Association.

Nonparticipating hospital

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

Nonparticipating provider

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

Occupational therapy

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

- Develop, improve or restore the performance of necessary neuro-musculoskeletal functions affected by an illness or injury or following surgery.
- Help the patient learn to apply the newly restored or improved function to meet the demands of daily living.
- Design and use splints, orthoses (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.

Glossary of health care terms

Out-of-area services

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

Out-of-network provider

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

Outpatient psychiatric facility

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

Outpatient substance abuse treatment program

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

Partial liver

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

Participating ambulatory surgery facility

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

Participating hospital

A hospital that has signed a participation agreement with BCBSM to accept the approved amount as payment in full. 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 health care 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.

Glossary of health care terms

Peripheral blood stem cell transplant

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

Pheresis

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

Physical therapy

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

- Muscle strength
- Coordination
- Joint motion
- General mobility

Physician

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

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

Physicians may also be referred to as "practitioners."

Plaintiff

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

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.

Glossary of health care terms

Preferred Provider Organization (PPO)

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

Primary payer

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

Professional provider

This refers to one of the following:

- Doctor of medicine (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)
- Other providers as identified by MESSA/BCBSM
- Clinical licensed master's social worker (CLMSW)
- Licensed professional counselor (LPC)
- Oral surgeon
- Board certified 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)

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.

Psychologist

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

Glossary of health care terms

Routine patient costs

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

- The investigational item, device or service itself.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient, or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Screening services

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

Service area

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

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

Services

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

Skilled care

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

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

Skilled nursing facilities

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

Glossary of health care terms

Specialty hospitals

Hospitals that treat specific diseases, such as mental illness.

Specialty pharmaceuticals

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

Specialty pharmacy

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

Speech and language pathology services

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

Stem cells

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

Subrogation

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

Substance abuse

Taking alcohol or other drugs in amounts that can:

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

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

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.

Glossary of health care terms

Technical surgical assistance

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

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

Terminally ill

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

Total body irradiation

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

Urgent care

Walk-in care needed for an unexpected illness or injury that requires immediate treatment to prevent long-term harm.

Urgent care centers are not the same as emergency rooms or doctors' offices.

Voluntary sterilization

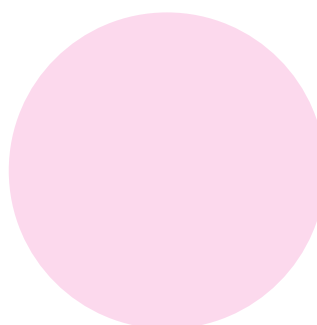
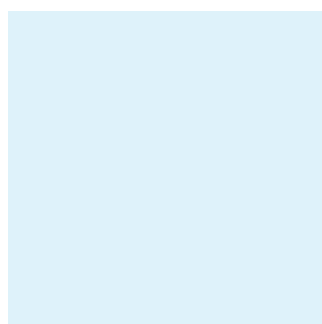
Sterilization that is not medically necessary according to generally accepted standards of medical practice and is performed strictly at the request of the patient.

We, us, our

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

You and your

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





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