MESSA

# ChoicesII

## Group Insurance for School Employees

MESSA®

www.messa.org

Welcome to our family. As a member of the Michigan Education Special Services Association (MESSA), you are part of a 100,000 member family affiliated with the state's largest school employee union, the Michigan Education Association (MEA).

This coverage booklet explains the MESSA Choices II program in detail, describes the program's benefits and limitations, and outlines how the program works. This will help you understand your benefits and financial responsibilities before you require services.

The demands of providing quality health care for our members are sometimes challenging. However, we are dedicated to quality service, committed to listening to members' varying needs, and resolved to meeting the demands placed upon us by the health care industry.

Throughout our relationship, we will provide you with the highest level of dedication and excellence in service. Your health coverage is made available by the Group Agreement between MESSA and Blue Cross Blue Shield of Michigan (BCBSM) and the MESSA/BCS Life Insurance Company (BCS) Group Policy. BCBSM and BCS underwrite this coverage. Administration of your program is shared between MESSA and BCBSM. Life and Accidental Death and Dismemberment (AD&D) coverage is underwritten by Connecticut General Life Insurance Company (Connecticut General).

From time to time, you may have questions about your benefits or coverage under this MESSA Choices II coverage booklet. For answers to your questions about your benefits, you should contact MESSA.

We hope your affiliation with MESSA/MEA is continuous and beneficial.

Your Family of MESSA

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# About Your Coverage

This coverage booklet is arranged to help you locate information easily. You will find:

- A Table of Contents for quick reference
- The Language of Health Care - explanations of the terms used in your coverage booklet
- Information About Your Coverage
- What You Must Pay
- Coverage for Hospital and Facility Services
- Mental Health and Substance Abuse Services
- Coverage for Physician and Other Professional Provider Services
- Coverage for Other Health Care Services
- Exclusions and Limitations
- General Conditions of Your Coverage
- How to File a Claim

The term **patient** refers to either you or one of your enrolled dependents when you receive covered services. Your enrolled dependents are those who are listed on your application and who meet the eligibility guidelines described in this coverage booklet.

This coverage booklet provides you with the information you need to get the most from your health care coverage. Please call MESSA if you have any questions.

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# Section 1: The Language of Health Care

This section explains the terms used in your coverage booklet.

**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, or 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").

**Acquisition Cost**
The actual cost of the hearing aid to the audiologist, hearing aid specialist, or dealer.

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

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

- custodial, convalescent, tuberculosis, or rest care
- care of the aged or substance abusers
- skilled nursing or other nursing care

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

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

**Ambulatory Surgery Facility**
A freestanding outpatient surgical facility offering surgery and related care that can be safely

performed without the need for overnight inpatient hospital care. It does not include an office of a physician or other private practice office.

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

**Approved Amount**
The lower of the billed charge or our maximum payment level for the covered service. Co-payments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

**Approved Hospice**
A hospice provider that meets all state licensing and MESSA/BCBSM approval requirements.

**Attending Physician**
The physician in charge of a case and the one exercising overall responsibility for the patient's care.

**Audiologist**
A person who is qualified in the state in which services are provided and certified by the American Speech and Hearing Association to conduct audiometric examinations and hearing aid evaluation tests on individuals with impaired hearing.

**Audiometric Examination**
A procedure to evaluate the patient's hearing and measure hearing loss.

**Autologous Bone Marrow 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.

**BCS**
BCS Life Insurance Company.

**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 Participating PPO Provider**
A provider who participates with the host plan's PPO.

**BlueCard Program PPO**
A national program that allows Blue Cross Blue Shield of Michigan PPO members to receive health care services in other states.

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

**Conformity Test**
A follow-up visit to the physician-specialist or audiologist who prescribed the hearing aid to verify that the patient received the prescribed hearing aid and to evaluate its effectiveness.

**Connecticut General**
Connecticut General Life Insurance Company, one of its affiliated companies, or their designee.

**Copayment**
The portion of the approved amount that you must pay for a covered service after your deductible has been met.

**Covered Services**
The services, treatments or supplies identified as payable in your Certificate.

*Note: Covered services must be medically necessary to be payable (see definition of "Medically Necessary").*

**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.

**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.

**Dispensing Fee**
The amount we pay the provider for supplying a hearing aid, including the cost of an ear mold.

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

**Ear Mold**
A device made of soft rubber, plastic, or nonallergenic materials, vented or nonvented, that is fitted to the outer ear canal and pinna of the patient.

**Effective Date**
The date your coverage begins under this contract. This date is established by MESSA and BCBSM.

**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**
A service that has not been scientifically demonstrated to be as safe and effective for treatment of the patient's condition as conventional or standard treatment.

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

**Fecal Occult Blood Screening**
A laboratory test to detect blood in feces or stool.

**First Aid**
Treatment given for an accidental injury.

**First Degree Relative**
An immediate family member; that is, a mother, father, sister or brother.

**Flexible Sigmoidoscopy**
A visual examination of the lower portion of the colon through the rectum, using a flexible instrument called a sigmoidoscope.

**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.

**Genetic Markers**
Specific chemical groupings that are part of many body cells, including white blood cells. Called human leukocyte antigens (HLA), these six chemical groupings are inherited from each parent and are used to detect the constitutional similarity of one person to another. A complete HLA match occurs when all six of the clinically important markers of the donor are identical to those of the patient.

**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 potential risk factors.

**Hearing Aid**
An electronic device worn by the patient to amplify sound and improve the patient's hearing. A hearing aid may include an ear mold.

**Hearing Aid Evaluation Test**
A series of subjective and objective tests used by an audiologist or physician-specialist to determine what model and make of hearing aid should be prescribed to improve the patient's hearing.

**Hearing Aid Specialist/Dealer**
Any person or organization licensed to sell hearing aids prescribed by a physician-specialist or audiologist.

**High-dose Chemotherapy**
A procedure that involves giving patients cell destroying drugs in doses higher than approved by the FDA for therapy. This treatment is often life threatening and requires that bone marrow and/or peripheral blood stem cell transplants, transfusions, drugs or potent antibiotics be given to the patient in order to treat adverse side effects of high dose chemotherapy.

**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.

**Independent Physical Therapist**
A licensed physical therapist who is not employed by a hospital, physician or freestanding outpatient physical therapy facility and who maintains an office, separate from a hospital or freestanding outpatient physical therapy facility, with the equipment necessary to adequately provide physician-prescribed physical therapy.

**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 in order to be covered. There are two definitions: one applies to physician services and one applies to hospital services.

- **Medical necessity for payment of physician services:**
  Determination by physicians acting for BCBSM, based on criteria and guidelines developed by physicians for BCBSM who are acting for their respective provider type and/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.*

- **Medical necessity for payment of hospital services:**
  A determination that allows for the payment of hospital services when all of the following conditions are met:

  · the covered service is for the treatment, diagnosis of 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 by 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 services are not mainly for the convenience of the member or health care provider.

  · The treatment is not generally regarded as experimental or investigational by BCBSM.

  · The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment programs.

**Member**
An individual who is a member of MESSA.

**MESSA**
The Michigan Education Special Services Association.

**Nonpanel Provider**
Hospitals, physicians, and other licensed facilities or health care professionals who have not agreed to provide services to members enrolled in MESSA Choices II or do not participate with BCBSM.

**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-muculoskeletal functions affected by an illness or injury or following surgery
- help the patient learn to apply the newly restored or improved function to meet the demands of daily living
- design and use splints, ortheses (such as universal cuffs and braces) and adaptive devices (such as door openers, bath stools, large handle eating utensils, lap trays and raised toilet seats)

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

**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.

**Panel Providers**
Hospitals, physicians and other licensed facility or health care professionals who provide services to members enrolled in MESSA Choices II, participate with BCBSM or participate on a per claim basis. Panel providers have agreed to accept our approved amount as payment in full for covered services provided through the MESSA Choices II program.

**Pap Smear**
A method used to detect abnormal conditions, including cancer of the female genital tract.

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

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

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

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

**Patient**
The member or eligible dependent who is awaiting or receiving medical care and treatment.

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

**Peripheral 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) after which the remaining components are reinfused into the patient or donor.

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

- muscle strength
- joint motion
- coordination
- general mobility

**Physician**
A physician is a doctor of medicine (MD) or osteopathy (DO) legally qualified and licensed to practice medicine and perform surgery at the time and place services are performed. An optometrist, dentist, podiatrist, or a doctor of chiropractic 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.

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.

**Preferred Provider Organization**
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.

**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.

**Purging**
A process in which all abnormal cells in a sample are separated to obtain a clean sample with only normal blood producing cells.

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

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

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

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

**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.

**Semi-Private Room**
A hospital room with two beds.

**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.

**Specialty Hospitals**
Hospitals that treat specific diseases, such as mental illness.

**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.

**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
- endanger the safety or welfare of others because of the substance's habitual influence on the person

**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.*

**Total Body Radiation**
A process that uses intensive x-ray treatment to attempt to suppress all existing cancer cells. This treatment also affects normal cells.

**We, Us, Our**
Used when referring to MESSA, BCBSM and/or BCS.

**You and Your**
Used when referring to any person covered under the member's coverage.

# Section 2: Information About Your Coverage

## Who is Eligible for Coverage

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

- any active associate, service associate, retiree or student member of the Michigan Education Association as defined in the MEA bylaws
- any member of a bargaining unit in an educational agency in which a local association of MEA is the recognized bargaining agent and has negotiated MESSA benefits for its members
- any administrator employed by an educational agency in which a local association of the MEA is the recognized bargaining agent and has negotiated MESSA benefits for its members
- any retiree eligible for benefits under Section 91 of The Public School Employee Retirement Act of 1979, being MCLA 38.1391, as amended
- any other eligible individual as defined in the Michigan Education Special Services Association bylaws as constituted on May 20, 1988, as amended

An application is required if you are:

- enrolling for the first time
- changing coverage for yourself or your dependents
- changing school districts
- covering dependent children age 19 or older

## Eligible Dependents

If you are covered, your eligible dependents include:

- your spouse
- your unmarried children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until the end of the calendar year of their 19th birthday
- your unmarried children beyond the end of the calendar year of their 19th birthday to the end of the calendar year of their 25th birthday who are dependent on you for a majority of their support (Dependency for tax purposes, as defined by the IRS, is not required.)

- your unmarried children beyond the end of the calendar year of their 25th birthday (if covered under this program at the end of the calendar year of their 25th birthday and continuously thereafter) who are mentally retarded or physically handicapped, dependent upon you for a majority of their support and who are incapable of self-sustaining employment by reason of their mental retardation or physical handicap. (Under no circumstances will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.) Please contact MESSA to obtain the appropriate form to continue coverage.

- your unmarried children beyond the end of the calendar year of their 25th birthday (if covered under this program at the end of the calendar year of their 25th birthday and continuously thereafter) who are full time students and dependent on you for a majority of their support.

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

It is your responsibility to notify MESSA and your employer:

- of any change in your employment status

- when you wish to add a spouse and/or dependent(s)

- of any change to a dependent's eligibility for coverage

- when a spouse and/or dependent is no longer eligible as defined above.

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

*Note: Life and Accidental Death & Dismemberment Insurance applies to covered members only. It does not apply to dependents.*

## When Coverage is Effective

The following information details the guidelines for your effective date of coverage:

- If you are a new employee and enroll for coverage within 31 days following the date you became eligible (your date of employment or the day following completion of the eligibility waiting period, whichever is later), your coverage will be effective on the date you became eligible. This date is verified by your employer.

- During open enrollment, the effective date of coverage for all new applications and coverage changes will be that date approved by MESSA and verified by your employer.

- If your application is submitted at any other time, your coverage will be effective on the first day of the month following approval of your application by MESSA.

- If you are absent from work because of bodily injury or sickness on the date your coverage would otherwise become effective, your coverage will not become effective until the day you return to active work. To be considered actively at work for coverage purposes, you must be physically and mentally able to perform your normal duties for a regularly scheduled workday when you report to work.

- Each dependent will be eligible for coverage on the later of the date on which your coverage begins or the date he/she becomes an eligible dependent if enrolled within 31 days. If your application for dependent coverage is submitted at any other time, coverage will be effective on the first day of the month following approval of your application by MESSA.

- If an eligible dependent is confined to a hospital or other medical facility (by reason other than his/her birth therein and the member has active coverage with MESSA at the time of birth) on the date the dependent would normally become eligible for coverage, the dependent's coverage will not become effective until his/her discharge from the hospital or other medical facility, provided your coverage is in effect at that time.

- 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 Terminates

MESSA Choices II benefits end on the first day of the calendar month in which a covered individual becomes age 65. On that date, you will be enrolled in the MESSA Limited Medicare Supplemental Plan. If, however, you continue active school employment and remain a MESSA member, your MESSA Choices II coverage and that of your covered dependents will not end until the first of the following circumstances occurs:

**Termination of Employment** - Coverage will end on the last day of the month in which you terminate employment.

**Nonpayment of Contributions** - Coverage will end on the last day of the month preceding the month for which the required contribution has not been remitted to MESSA.

**Termination of Employer's Participation** - Coverage will end on the last day of any month in which your employer ceases to participate under the MESSA/BCBSM/BCS Group Agreement.

**Member No Longer Eligible** - Coverage will end on the last day of the month in which a member no longer meets the eligibility criteria described in this section.

**Dependent No Longer Eligible** - Coverage will end on the date a dependent no longer meets the eligibility criteria described in this section.

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

**Termination of the MESSA/BCBSM Group Agreement and/or the MESSA/BCS Group Policy and/or the Group Policy with Connecticut General** - Coverage will end on the date the MESSA/BCBSM Group Agreement and/or the MESSA/BCS Group Policy and/or the Connecticut General Group Policy terminates.

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

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

## Continuation of Coverage

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

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

We have listed the most common qualifying events.

You and your dependent(s) must pay the required contribution, if any, for the continued coverage. Your employer will inform you of the monthly contribution to be paid. In the event of your divorce or legal separation or if your dependent child ceases to be eligible as a dependent under the program, you or your dependent must notify the plan administrator (your employer) of the occurrence of the qualifying event within 60 days after it occurs or the date coverage is terminated, whichever is later.

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

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

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

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

- the first day for which timely payment for the qualifying beneficiary is not made to the plan
- the date upon which your employer terminates participation under the MESSA/BCBSM/BCS Group Agreement/Policy that provides the benefits described in this coverage booklet
- the date the qualified beneficiary becomes covered under any other group health plan that is not maintained by your employer (other than a plan containing limitations or exclusions with respect to a pre-existing condition of the qualified beneficiary)
- the date the qualified beneficiary becomes entitled to benefits under Medicare.

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

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

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

### Conversion Privilege

When you are no longer eligible for the MESSA Choices II program through your employer, an individual health care plan is available to you through BCBSM/BCS. Your benefits will change and coverage will be limited to your immediate family. There will be no interruption of coverage, provided you pay the premiums when due. To ensure continuous coverage, you must make application within 31 days from the date your coverage terminates with your employer. Contact MESSA for additional information on how to apply for this coverage.

### Surviving Family

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

# Life and Accidental Death and Dismemberment (AD&D) Benefits

Connecticut General Life Insurance Company

hereby certifies that members of

Michigan Education Special Services Association

(called the Policyholder)

who are insured under Group Policy No. 57200 are subject to the terms and conditions of this policy and are insured for the benefits described in the pages of this booklet.

Connecticut General Life Insurance Company, called Connecticut General, insures the life and accidental death and dismemberment benefits. Connecticut General will determine all benefit payments according to the provisions described in the booklet and the group policy.

The insurance is effective only if the person concerned is eligible, becomes covered and remains covered, in accordance with the terms and conditions of the policy. Coverage applies to members only, as defined on page 11. Dependents are not eligible for either the life insurance or accidental death and dismemberment insurance benefits.

This certificate replaces any other certificate issued to you describing these benefits.

Connecticut General Life Insurance Company

PF75134 amended by PF33333

## Section 3: Life and Accidental Death and Dismemberment (AD&D) Benefits

### General Provisions

The following will explain the life and AD&D benefits available to you under the MESSA Choices II program.

***Beneficiary***

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

- spouse;
- children;

- parents;
- brothers and sisters.

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

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

If you die after having applied to convert your group life insurance to an individual insurance policy, the beneficiary named in the individual policy (or in the application for it) will receive any benefits payable under the group insurance policy.

***Assignment of Life Insurance***

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

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

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

Acceptance of an assignment by Connecticut General shall be without further liability as to any action or any payment or other settlement made by Connecticut General before such acceptance. No assignment by you of your accidental death and dismemberment (AD&D) insurance is valid.

## Life Insurance Benefits

The following information will explain your life insurance benefits under the MESSA Choices II program.

***How Payment is Made***

If you die while covered under the MESSA Choices II program, Connecticut General will pay your beneficiary $5,000. You may choose to have the benefit paid in a lump sum or in installments. You may also change your beneficiary or the method of payment at any time. Contact MESSA Group Services for the appropriate forms.

After your death, your beneficiary may choose the method of payment (if you have not already done so) and name a person to receive the benefit amount which would be paid to the beneficiary's estate in the event your beneficiary died before payment was made.

## Continuation of Life Insurance Coverage

*While Disabled*

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

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

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

To minimize the financial burden during your disability, your contributions towards life insurance will be waived.

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

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

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

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

*If You Die While Disabled*

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

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

*When Your Extended Coverage Ends*

Your extended coverage will end if you:

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

When your extended coverage ends, you can convert to an individual policy under the same conditions that would apply if you left school employment. See "After Employment Ends" below.

*After Employment Ends*

You have 31 days to convert to an individual policy and pay your first contribution. You won't need to take a health exam, but you will be limited in your choice of policy. The individual policy amount must be no greater than $5,000, and you cannot convert to a policy that provides term insurance, universal or variable life insurance, benefits for disabilities, or extra benefits for accidental death.

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

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

As an option to converting, you may continue your group life insurance on a direct payment basis by paying the required contribution for the cost of this insurance. MESSA will mail you a continuation notice for electing this option upon termination of your employment.

Contact MESSA Group Services for additional information.

*After your Employer Terminates Participation in the Group Policy, or Coverage for Your Job Classification Ends*

Again, you have 31 days to convert to an individual policy. The same conditions apply as if your employment ended. In addition, you must have been insured by the group policy for at least five years in a row.

The maximum amount of life insurance you may convert is $2,000, less any amount you became eligible for under any other group policy during the 31-day conversion period.

Should you die in the 31-day period after your participation ends, or after the group policy itself terminates, and you were insured by the group policy for the preceding five years, you are still covered. Connecticut General will pay your beneficiary the group life insurance policy amount, less the amount of any other group policy under which you became insured during that 31-day period, up to a maximum of $2,000.

Even if you should die within the 31-day conversion period without converting, Connecticut General will still pay your beneficiary the amount you could have converted.

## Accidental Death and Dismemberment (AD&D) Benefits

The following information will explain your AD&D benefits under the MESSA Choices II program.

*What is Covered*

As a MESSA member you have $5,000 of AD&D insurance. If, while you are covered, you receive a bodily injury and experience a loss, Connecticut General will pay you according to the

schedule listed under "How AD&D Benefits are Paid."

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

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

All benefits other than loss of life will be paid to you. If you die, the benefits will be paid to your beneficiary. See "General Provisions" in this section for details about your beneficiary.

You may change your beneficiary at any time. Contact MESSA Group Services for the appropriate forms.

***How AD&D Benefits are Paid***

| **For the Loss of:** | **You Receive:** |
|---|---|
| Life<br>Both hands or both feet<br>Sight in both eyes<br>Any two or more:<br>one foot<br>one hand<br>sight in one eye | 100%<br>of AD&D<br>Benefit<br>($5,000) |

| **For the Loss of:** | **You Receive:** |
|---|---|
| One hand, or<br>One foot, or<br>Sight in one eye, or<br>Speech, or<br>Hearing | 50%<br>of AD&D<br>Benefit<br>($2,500) |

| **For the Loss of:** | **You Receive:** |
|---|---|
| Thumb and index finger<br>of the same hand | 25% of AD&D Benefit<br>($1,250) |

The following defines what is considered a loss:

| **Definition** | |
|---|---|
| Loss of one hand or foot | Loss by cutting off at or above the wrist or ankle joint |
| Loss of sight, speech, or hearing | Total loss that cannot be recovered |
| Loss of thumb and index finger | Loss by cutting off at the proximal phalangeal joint |

***When You Suffer More Than One Loss***

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

question, regardless of any previous loss.

*Losses Not Covered*

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

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

*When Coverage Ends*

AD&D coverage ends when your school employment ends or when you reach 65 years of age, whichever happens last. If your school employment ends before your reach 65, you must pay the required contribution for the cost of this insurance to continue this coverage until you reach age 65.

# Health Care Benefits

Underwritten By
Blue Cross Blue Shield of Michigan
(BCBSM)
and
BCS Life Insurance Company
(BCS)

## Section 4: What You Must Pay

This section explains the deductibles and copayments you must pay each calendar year. It also explains the annual and lifetime maximums we will pay.

### Panel Providers

*Deductible Requirements*
You pay no deductible for covered services provided by panel providers.

*Copayment Requirements*
You are required to pay the following flat dollar copayments or percentage copayment for each covered service provided by panel providers:

- $25 copayment per visit for facility services in a hospital emergency room. This copayment is waived if the patient is admitted or if the services are required to treat an accidental injury.
- $5 copayment per office, outpatient, home medical care visit or office consultation. This copayment requirement is **not** imposed for:
  - first aid and medical emergency treatment in a physician's office
  - pre and post natal care
  - allergy testing and therapy
  - immunizations and therapeutic injections
- $10 copayment for urgent care visits. This copayment is waived if services are required to treat a medical emergency or accidental injury.
- 10 percent copayment of the approved amount for private duty nursing care, outpatient substance abuse treatment and outpatient mental health care (including psychiatric testing).

When you receive covered services from a panel provider, we will pay the approved amount directly to the provider. You are responsible only for the flat dollar copayments and percentage copayments described in this coverage booklet.

## Nonpanel Providers

*Deductible Requirements*
You are required to pay the following deductible each calendar year for covered services provided by nonpanel providers:

- $250 for one member
- $500 for the family (when two or more members are covered under your contract)
  - two or more members must meet the family deductible
  - if the one member deductible has been met, but not the family deductible, we will pay covered services only for that member who has met the deductible
  - covered services for the remaining family members will be paid when the full family deductible has been met.

*Note: Deductibles paid in one calendar year are not applied to the deductible you must pay the following year.*

When you receive covered services from a nonpanel provider, you will be required to pay a deductible for most covered services. However, you will not be required to pay a deductible if:

- a panel provider refers you to a nonpanel provider
- you receive services for the initial exam to treat a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- you receive services from:
  - home health care agencies
  - hospice programs
  - ambulance providers
  - durable medical equipment suppliers
  - prosthetic and orthotic suppliers
  - freestanding physical therapy facilities
  - ambulatory surgery facilities
  - skilled nursing facilities

*Copayment Requirements*
You are required to pay the following flat dollar copayment or percentage copayments for each covered service provided by a nonpanel provider:

- $25 copayment for facility services in a hospital emergency room. This copayment requirement is waived if the patient is admitted or if the services are required to treat an accidental injury.

- 10 percent copayment of the approved amount for private duty nursing services.
- 20 percent of the approved amount for most other services, including inpatient and outpatient mental health care (including psychiatric testing) and substance abuse treatment, which contributes toward your annual copayment maximum for nonpanel services.

*Note: Mental health care and substance abuse treatment have special payment limitations. See Section 6 of your certificate for details.*

Your annual copayment maximum for nonpanel services is:

- $2,000 for one member
- $4,000 for two or more members

Once the annual copayment maximum is met, no more copayments will be required for the remainder of the year, except that copayments continue to be required for private duty nursing.

*Note: Copayments for private duty nursing are not applied to your annual copayment maximum.*

You will not be required to pay a percentage copayment if:

- a panel provider refers you to a nonpanel provider
- you receive services for the initial exam to treat a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- you receive services from:
  - home health care agencies
  - hospice programs
  - ambulance providers
  - durable medical equipment suppliers
  - prosthetic and orthotic suppliers
  - freestanding physical therapy facilities
  - ambulatory surgery facilities
  - skilled nursing facilities

We will not apply charges toward your deductible or copayment requirements for panel and nonpanel providers that:

- exceed our approved amount
- are for noncovered services and limited covered services (i.e., accidental injuries and medical emergencies), or
- apply to deductibles or copayments paid under other health care coverages.

### Care Outside of Michigan

If you or a covered dependent receives treatment in an accredited non-Michigan hospital, just show your MESSA/BCBSM identification card. The hospital billing office will send the bill directly to MESSA or the local Blue Cross plan.

If you or a covered dependent receives any other type of service performed by a physician practicing outside of Michigan, the physician's billing office will either bill the local Blue Cross plan directly or provide you with an itemized statement or receipt. Send the itemized statement to MESSA. If written authorization is attached to the statement, MESSA will pay the provider, otherwise, payment will be sent to you.

## Section 5: Coverage for Hospital and Facility Services

### Coverage is available for:

- Inpatient Hospital Services
- Outpatient Hospital Facility Services
- Human Organ Transplants
- Bone Marrow Transplants
- Freestanding Ambulatory Surgery Facility Services
- Home Health Care Services
- Hospice Services
- Skilled Nursing Facility Services

All services must be prescribed by your physician and determined to be medically necessary. See Section 1 for definitions.

See Section 4 for further details about "What You Must Pay."

### Inpatient Hospital Benefits

After you have followed the Pre-Admission Review (PAR) requirements explained below and your admission has been determined by MESSA to be medically necessary, benefits will be paid as indicated under "Inpatient Hospital Benefits." If you do not satisfy the following requirements, you may have additional financial responsibilities in excess of the deductible and copayments.

### Pre-Admission Review (PAR)

*Panel and Participating Hospitals*
The hospital will take care of this requirement for you.

*Nonparticipating Hospitals*
If you are using a nonparticipating hospital, then you, your doctor or hospital must request prior approval for all elective (non-emergency) admissions to a hospital.

- A completed Pre-Admission Review form must be sent to MESSA at least two weeks before the scheduled admission. Mail it to MESSA at:

  Michigan Education Special Services Association
  Pre-Admission Review
  P.O. Box 2560
  East Lansing, MI 48826-2560

  OR

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

*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 BCBSM's medically necessary criteria, and will provide written notice to you, your doctor and the hospital.

*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, your doctor and the hospital know if the request for additional days has been approved.

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

- charges for inpatient hospital room and board
- other charges for medical services and supplies furnished by the hospital
- physician charges for inpatient hospital visits
- any other charges related to the days not approved

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

*Appealing a Non-Approved Admission or Extension*
Your doctor may appeal all decisions by requesting a review by MESSA.

*Receiving Services Without Prior Approval*
If the required Pre-Admission Review is not obtained, those covered charges stated above which are determined to be medically necessary for inpatient hospital confinement and physician in-hospital visits will be reimbursed at 80 percent of the amount, after deductible, that would otherwise have been paid in accordance with the MESSA Choices II plan and Pre-Admission Review. You will be responsible for the remaining 20 percent. The disadvantage to receiving services without prior approval is that you will not know before the admission whether care is covered.

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, you will be responsible for all charges (both hospital and doctor) resulting from the admission.

## Outpatient Hospital Facility Services

When performed in the outpatient department of a hospital, benefits include:

*First Aid Emergency Care*
Outpatient treatment due to an accidental injury is paid at 100 percent of the approved amount for hospital and/or doctor services. Benefits include the initial examination and treatment.

*Medical Emergency Care*
The initial examination and treatment of conditions determined to be medical emergencies are payable when provided in an outpatient department of a hospital, subject to a flat dollar copayment of $25 per visit.

*Note: This $25 copayment is not applied if:*
*- the patient is admitted*
*- services were required to treat an accidental injury*

*Scheduled Outpatient Surgery*
Hospital charges for covered scheduled outpatient surgery are paid according to the provisions in Section 7.

## Human Organ Transplants

Services for kidney, cornea and skin transplants are covered as standard benefits provided by this certificate. They are not subject to guidelines outlined in this section.

Human organ transplant services must be preapproved. The preapproval process allows a provider to know if we will cover the proposed human organ transplant surgery, related services, hospital admission and length of stay at the hospital before treating you. If preapproval is not obtained before you receive the human organ transplant services described below, they will not be covered.

A decision to preapprove services will be based on the information your provider submits for review. BCBSM/MESSA reserves the right to request other information to determine if preapproval is approriate.

When performed in a BCBSM-designated facility, we pay the approved amount, minus required deductible and copayments for transplantation of the following human organs:

- heart
- heart-lung(s)
- liver
- lung(s)
- pancreas
- partial liver
- lobar lung
- simultaneous pancreas-kidney
- small intestine (small bowel), pediatric only
- combined small intestine-liver, pediatric only

*Note: A small bowel transplant is considered medically necessary in pediatric patients with short bowel syndrome who have established long-term dependency on total parenteral nutrition and have developed severe complications due to parenteral nutrition.*

*A small bowel transplant is considered experimental for adults. See the "General Conditions" section of this coverage booklet for guidelines related to experimental procedures.*

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

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 directly related to the transplant, we pay for:

- facility and professional services
- anti-rejection drugs and other transplant-related prescription drugs, as needed. Our payment will be based on the amount we determine to be reasonable and necessary and is subject to the **$1,000,000** lifetime maximum for the human organ transplant benefit under this coverage booklet.
- medically necessary services needed to treat a condition arising out of the organ transplant surgery **if** the condition:

  · occurs <u>during</u> the benefit period and

  · is a <u>direct</u> result of the organ transplant surgery

*Note: We will pay for any medically necessary service needed to treat a condition as a result of the organ transplant surgery, if it is a benefit under any of our certificates.*

We also pay for the following:

- up to $10,000 for travel, meals and lodging. This includes:
  - cost of 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)
  - reasonable and necessary costs of lodging for the person(s) eligible to accompany the patient
  - reasonable and necessary costs of meals up to $30 per day for the patient and person(s) eligible to accompany the patient
- cost of acquiring the organ. This includes:
  - surgery to obtain the organ
  - storage of the organ
  - transportation of the organ
  - payment for covered services for donors if the donor does not have transplant services under any health care plan

*Note: We will pay what we determine to be reasonable and necessary for the cost of acquiring the organ. The total payment for all services combined for each organ transplant will not be more than the $1,000,000 lifetime maximum for the specified human organ transplant benefit under this coverage booklet.*

### Bone Marrow Transplants

We pay for:

- autologous bone marrow and peripheral blood stem cell transplants (including harvesting and storing the marrow and/or peripheral blood stem cells for a transplant intended to be performed within one year)
- allogeneic bone marrow and peripheral blood stem cell transplants (including harvesting the marrow and/or peripheral blood stem cells) 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 and matches five of the six important HLA genetic markers with the patient
- high-dose chemotherapy
- total body radiation

- blood tests on first degree relatives to evaluate them as donors (if the tests are not covered by their insurance)
- a search of the National Bone Marrow Donor Program Registry for a donor

*Note: A search will begin only when the need for a donor is established.*

- infusion of colony stimulating growth factors
- hospitalization in an intensive care unit, special care unit or private room
- services you receive as a donor of bone marrow and/or peripheral blood stem cells (e.g., infusion of growth stimulating factors, hospitalization, blood tests and harvesting as detailed above)

*Allogeneic bone marrow and peripheral blood stem cell transplants are covered to treat:*

- acute lymphocytic leukemia
- acute non-lymphocytic leukemia
- aplastic anemia
- beta thalassemia, major
- chronic myeloid leukemia
- Hodgkin's disease (relapsed and stage III or IV)
- Hurler's syndrome
- myelodysplastic syndromes
- neuroblastoma (stage III or IV)
- non-Hodgkin's lymphoma (intermediate or high grade)
- osteopetrosis
- severe combined immune deficiency disease
- Wiskott-Aldrich syndrome
- sickle cell disease (when complicated by stroke)
- myelofibrosis

*Autologous bone marrow and peripheral blood stem cell transplants are covered to treat:*

- acute lymphocytic leukemia
- acute non-lymphocytic leukemia
- germ cell tumors of the ovary, testis, mediastinum,retroperitoneum

- Hodgkin's disease (state III or IV)
- neuroblastoma (stage III or IV)
- non-Hodgkin's lymphoma (intermediate or high grade)
- metastatic breast cancer (stage IV)
- multiple myeloma
- primitive neuroectodermal tumors
- Ewing's sarcoma
- medulloblastoma
- Wilms' Tumor

*Note: We also pay for any services related to or for high-dose chemotherapy, total body radiation, allogeneic or autologous bone marrow and/or peripheral blood stem cell transplants to treat conditions other than those listed above if the services are not otherwise excluded from coverage as experimental or investigational.*

*We also pay for antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.*

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

We do not pay for:

- any services related to or for allogeneic bone marrow transplants and/or peripheral blood stem cell transplants when the donor does not meet the HLA genetic marker matching requirements
- purging of and/or positive stem cell selection of:
  - bone marrow stem cells or
  - peripheral blood stem cells
- harvesting and storage costs of bone marrow and/or peripheral blood stem cells if not intended for transplant within one year
- health care services provided by persons who are not legally qualified or licensed to provide such services
- services that are not medically necessary ("Medically Necessary" is defined in Section 1)
- any facility, physician or associated services related to any of the above named exclusions

## Ambulatory Surgery Facility Services

We pay for medically necessary facility services provided by an ambulatory surgery facility. The services must be directly related to performing ambulatory surgery.

## Home Health Care Services

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 Services

Hospice benefits allow covered terminally ill patients to spend their final days at home or in a special hospice facility as approved by MESSA/BCBSM. 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 six 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.

The following services for the patient will be paid up to a maximum which is reviewed and adjusted periodically (call MESSA for information about the current maximum amount). All of the following services are covered:

- inpatient care provided by a hospice inpatient unit, hospital or skilled nursing facility contracting with the hospice program
- occasional respite care of up to five days duration, within a 30 calendar day period, to relieve family members or other persons caring for the member at home
- part-time skilled nursing care (full-time 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
  - 18 months after the date the hospice benefit began or
  - upon payment of the maximum hospice benefit payment, whichever occurs first

See Section 4 for details about your copayment responsibilities.

## Skilled Nursing Facility Services

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*.

# Section 6: Mental Health and Substance Abuse Services

All services must be medically necessary and provided by an eligible provider.

## Eligible Providers

The network contains the following mental health and substance abuse treatment provider types who have agreed to provide services to MESSA members enrolled in MESSA Choices II:

- Licensed physicians
- Psychiatrists
- Fully licensed psychologists
- Certified clinical social workers*
- Certified nurse specialists in mental health*
- Hospital-based mental health facilities
- Outpatient psychiatric care facilities
- Hospital-based and freestanding residential substance abuse facilities
- Outpatient substance abuse treatment programs

**Services from these providers are covered only if performed in a panel outpatient psychiatric care facility or under the direct supervision of an MD or DO.*

## What You Must Pay

## Panel Provider

*Inpatient Care*
All care must be medically necessary and your panel provider must preapprove all services. Care is payable as follows for a panel hospital, residential substance abuse treatment facility or panel halfway house:

- no deductible
- 100 percent of the approved amount
- no limit on hospital days as long as days are authorized

*Outpatient Care*
All care must be medically necessary. Care is payable as follows for a licensed mental health facility, substance abuse facility or outpatient treatment facility by an eligible provider:

- no deductible
- 10 percent copayment of the approved amount for each visit

- A combined limit of 50 panel and nonpanel visits per member, per calendar year for outpatient mental health care (psychiatric testing does not count toward this visit maximum)

### Nonpanel Provider

*Inpatient Care*
Inpatient care must always be medically necessary. Care is payable as follows for services provided in a nonpanel hospital or residential substance abuse treatment facility:

- 20 percent of the approved amount for each visit, which contributes toward your annual copayment maximum for nonpanel services
- Services are subject to the nonpanel deductible

***Outpatient Care***
Medically necessary outpatient care in a licensed mental health facility, substance abuse facility or outpatient treatment facility by an eligible provider is payable as follows:

- 20 percent copayment of the approved amount (for each visit), which contributes toward your annual copayment maximum for nonpanel services
- Services are subject to the nonpanel deductible
- A combined limit of 50 panel and nonpanel visits per member, per calendar year for outpatient mental health care (psychiatric testing does not count toward this visit maximum)
- Unlimited visits for outpatient substance abuse treatment when provided in a licensed substance abuse facility

## Section 7: Coverage for Physician and Other Professional Provider Services

This section describes physician and other professional provider services covered by your coverage booklet.

All services must be medically necessary to be covered.

See Section 4 for details about your copayment responsibility.

### Physician Services That are Payable

Other than voluntary sterilization, screening mammography and preventive care services, covered services must be medially necessary to be paid. (Medically Necessary" is defined in Section 1.)

We pay our approved amount for the physician services described in this section (deductible and copayment information is in Section 4.)

## Surgery

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 physician 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 percent of our approved amount for the less costly procedure(s)

*Note: Determination of the more or less difficult procedure is based on the BCBSM approved amount.*

*Panel and participating providers follow these guidelines and agree to accept our payment as payment in full. However, nonpanel and nonparticipating providers may bill you for the difference between the approved amount, less any required deductible and copayments, and billed charges.*

## Dental Surgery

Dental surgery is payable **only** for:

- multiple extractions or removal or unerupted teeth, alveoloplasty 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

## Anesthesia

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

- a physician, other than the physician performing the service
- a physician who orders and supervises anesthetist services

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

We do not pay for local anesthetics.

### Cosmetic Surgery

Cosmetic surgery is payable for the following conditions:

- the correction of conditions resulting from an accidental injury
- an illness (or accidental injury) if the injury occurred or the illness was contracted while covered under this plan; and only if coverage has been continuous since the date of the accidental injury or the date the illness was contracted

*Note: Cosmetic surgery for beautifying purposes primarily performed to improve appearance is not covered.*

### Technical Surgical Assistance (TSA)

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 TSA. A list of covered and approved TSA surgeries and additional information is available from MESSA.

We do not pay for TSA:

- 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

### Obstetrics

Prenatal and postnatal services are payable, as are services provided by the physician attending a birth.

### Newborn Examination

A newborn's first routine physical exam is payable when provided during the inpatient hospital stay. The exam must be provided by a doctor other than the anesthesiologist or the attending physician.

*Note: You must notify us within 30 days of the newborn's birth so we can add the newborn to your contract. You should contact MESSA for additional information.*

### Medical Care

We pay medical care by your attending physician while you are in the hospital or in a skilled nursing facility.

## Inpatient and Outpatient Consultations

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

We do not pay for staff consultations required by a facility's or program's rules.

*Note: Consultations in a panel physician's office are subject to a flat $5 copayment requirement.*

## Emergency Treatment

We pay for services of one or more physicians for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office.

*Note: Deductible and copayments are not required for these emergency panel or nonpanel physician services.*

## Chemotherapy

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, BCBSM's Medical Policy Department determines 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

### End Stage Renal Disease

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.

*Note: Physician services for the treatment of ESRD are covered in coordination with Medicare. It is important that individuals with ESRD apply for Medicare coverage through the Social Security Administration. BCBSM 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.*

### Therapeutic Radiology

We pay for physician services to treat medical conditions by x-ray, radon, radium, external radiation or radioactive isotopes. The services must be provided by the attending physician or by another physician if prescribed by the attending physician.

### Diagnostic Radiology

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 may call MESSA for more information about any restrictions)

The services must be provided by the attending physician or by another physician if prescribed by the attending physician.

### Diagnostic Services

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

- thyroid function
- electrocardiogram
- electroencephalogram
- electromyogram
- nerve conduction
- pulmonary function studies

The services must be provided by the attending physician or by another physician if prescribed by the attending physician.

## Diagnostic Laboratory and Pathology Services

We pay for laboratory and pathology exams needed to diagnose a disease, illness, pregnancy or injury. The services must be provided by the patient's attending physician.

*Note: If the physician has a laboratory perform these services, it must be a panel laboratory. You will be required to pay the nonpanel copayment when services are provided by a nonpanel laboratory unless:*

- standard office laboratory tests approved by BCBSM are to be performed in a panel physician's office in connection with medical care
- the laboratory and pathology services are performed at a hospital on an inpatient or outpatient basis
- the services are performed by any participating substance abuse facility in connection with treatment of substance abuse
- your physician refers you to a nonpanel laboratory for tests (the physician must complete a referral form)
- services are received when you are enrolled for Medicare complementary coverage

## Allergy Services

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

- survey, including history, physical exam and diagnostic laboratory studies
- intradermal, scratch and puncture tests
- patch, photo, insufflate and provocative antigen tests
- procedures to desensitize patients to antigens or haptens
- ultrasound, radiotherapy and radiothermy treatments
- injections of antiallergen, antihistamine, bronchodilator or antispasmodic agents

We do not pay for:

- fungal or bacterial skin tests (such as those given for tuberculosis or diptheria)
- environmental studies, evaluation or control

## Chiropractic Services

We pay for spinal manipulation to treat misaligned or displaced vertebrae of the spine. Benefits are provided for a maximum of 38 visits per member, per calendar year. We also pay for x-rays when the diagnosis is an incomplete or partial dislocation in the spinal area.

*Note: Services provided by nonpanel providers are combined with services provided by panel providers to meet the 38-visit maximum per year. Copayments are not required when services are provided in a panel physician's office.*

## Therapy Services

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

Services are covered up to a **combined** benefit maximum of 60 visits per member, per calendar year, whether obtained from a panel or nonpanel provider. All services provided in any outpatient location (hospital-based, freestanding facility or physician's office) are combined to meet the 60 visit maximum. This benefit maximum renews each calendar year. We recommend that a course of treatment plan be submitted to MESSA before treatment begins.

Benefits include the following:

- Physical Therapy
  Services must be performed by 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 registered speech therapist. For non-developmental conditions, treatment is available for both adults and children. For congenital and severe developmental conditions, treatment is available only for children.

The following therapy services are also covered when medically necessary if obtained in an outpatient department of a hospital, doctor's office, or a freestanding facility (unless otherwise stated). See Section 4 for your copayment and/or deductible responsibilities.

- Chemotherapy
  Services for malignancy include the cost of administration, physician services and drugs, except when the treatment or drug is considered experimental or investigational

- Radiation Therapy
  Services for malignancy include x-rays, radium, external radiation or radioactive isotopes, except when the treatment is considered experimental or investigational.

- Vision Therapy
  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

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

## Office, Outpatient, and Home Medial Care Visits

We pay for office, outpatient and home medical care visits and consultations.

*Note: Only medically necessary services are payable, less applicable deductible and copayments.*

The following services will not require any copayments when provided in a panel **or** nonpanel physician's office:

- first aid and medical emergency treatment

The following services will not require any copayments when provided in a panel physician's office:

- prenatal and postnatal care
- allergy services
- immunizations and therapeutic injections

We do not pay for routine eye refractions and audiometric tests, **except** in connection with a medical diagnosis, pregnancy or injury.

## Voluntary Sterilization

We pay for voluntary sterilization.

## Screening Mammography

Routine mammography screening is available per the following schedule:

- for members between the ages of 35 and 40:
  - one initial routine baseline mammography
- for members age 40 and over:
  - one routine mammography screening per calendar year

## Preventive Care Services

We pay for the preventive care services listed below **only** when rendered by panel providers. Preventive care services do not have a dollar maximum per year, but are limited to visit maximums listed below. Copayments are **not** required for these services.

*Note: These preventive care services are currently recognized as standard screening procedures as related to health maintenance examinations:*

### Health Maintenance Examination

One examination per member, per calendar year. This comprehensive history and physical examination includes blood pressure measurement, ocular tonometry (measurement of pressure in the eye), skin exam for malignancy, breast exam, testicular exam, rectal exam and health counseling regarding potential risk factors.

### Flexible Sigmoidoscopy Examination

One routine flexible sigmoidoscopy examination per member, per calendar year.

### Gynecological Examination

One routine gynecological examination per member, per calendar year.

### Routine Pap Smear

Laboratory and pathology services for one routine Pap smear per member, per calendar year when prescribed and performed by a physician.

### Fecal Occult Blood Screening

One fecal occult blood screening per member, per calendar year to detect blood in the feces or stool.

### Well Baby and Child Care Visits and Immunizations

We pay for well baby and child care visits through age 15 as follows:

- six visits per year for children up to and including age 1
- two visits per year for children up to and including ages 2 through age 3
- one visit per year for children up to and including ages 4 through age 15

*Note: We also pay for childhood immunizations as recommended by the Advisory Committee on Immunization Practices and the American Academy of Pediatrics.*

### Prostate Specific Antigen Screening

We pay for one routine prostate specific antigen screening per member, per calendar year.

### Routine Laboratory and Radiology Services

We pay for the following services once per member, per calendar year, when performed as routine screening:

- chemical profile
- complete blood count or any of its components
- urinalysis
- chest x-ray
- EKG

# Section 8: Other Covered Health Care Services

This section describes coverage for other health care services in addition to your facility and physician services.

### Dental Services

Dental treatment by a licensed dentist or dental surgeon required because of an accidental injury to sound natural teeth sustained while covered by this plan and only if coverage has been continuous since the date of the accidental injury. Charges by a dental surgeon for the removal of cysts and tumors of the mouth and jaw, and the extraction of impacted teeth are covered.

### Durable Medical Equipment

Covered services include the rental cost, not to exceed the purchase price, of durable medical equipment when prescribed by a physician. Benefits include items such as hospital beds and/or wheelchairs. Items such as air purifiers, whirlpools, air conditioners and exercise equipment are not covered.

### Medical Supplies

We pay for medical supplies and dressings to be used in your home for the treatment of a specific medical condition.

### Medical Weight Loss Treatment

Services performed by a qualified physician for the treatment of morbid obesity are covered. Laboratory services, otherwise covered under the BCBSM plan, ordered for weight loss treatment are also covered. Services are covered up to $625 (this includes all services relating to this diagnosis) per special benefit period. To qualify for this benefit you must be one and one-half times the recommended normal weight. For this condition, a special benefit period begins with the date of the first service and ends three years following that date.

### Prescription Drug Benefits

Prescription drug benefits are provided by the MESSA Preferred Rx Program enclosed with this coverage booklet.

### Private Duty Nursing Services

We pay for private 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.

## Professional Ambulance Services

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

## Prosthetic and Orthotic Devices

Covered services include:

External appliances when they replace an absent part of the body or are intended to correct a defect of form or a function of the body. Appliances must be prescribed by a physician. Repairs or replacements are covered due to wear and tear or natural growth, unless otherwise specified. Benefits include, but are not limited to:

- external breast prostheses following a mastectomy. These include three post-surgical brassieres each calendar year. Additional brassieres are covered if they are required because of:
  - a significant change in body weight or
  - hygienic reason
- artificial eyes, ears, nose, larynx, limbs
- eyeglasses and hearing aids when required because of an accidental injury sustained while covered by this plan
- orthopedic shoes meeting guidelines established by MESSA and BCBSM
- one pair of prescription eyeglasses or contact lenses when required because of:
  - cataract surgery performed while covered by this plan
  - the absence of an organic lens
- prefabricated custom-made orthotic appliances
- external cardiac pacemakers
- maxillofacial prosthesis when BCBSM approved; these devices may be provided by dentists

## Medical Case Management (MCM)

This is a benefit designed to assist you if you are diagnosed with a catastrophic illness or injury. It is tailored to meet your unique medical needs. Approval of benefits will be based on an objective review of your medical status, current treatment plan, projected treatment plan, long-term cost implications and the effectiveness of care.

Eligibility for MCM benefits and termination of such benefits is made on a case-by-case basis in accordance with medically necessary criteria. The following medical conditions are examples of what may be considered for MCM:

- 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.

## Section 9: Hearing Care

This section describes coverage for hearing care services. These services require authorization from a physician. No coverage is available for these services without authorization.

Your physician must refer you to a physician-specialist who is board certified as an otologist, otolaryngologist, or otorhinolaryngologist. This physician-specialist determines whether the hearing loss can be offset by a hearing aid. The medical hearing loss examination is covered under the standard medical care benefits of this program and is not included in the maximum benefit limitation of this section.

Covered expenses are:

- An audiometric examination for either ear, or both ears, that

- is prescribed by a physician-specialist;
- is performed by a physician-specialist or audiologist or hearing aid specialist/dealer;
- is performed within six months of a medical hearing loss examination by a physician-specialist;
- includes tests for measuring hearing perception relating to air conduction, bone conduction, speech reception threshold and speech discrimination; and
- includes a summary of findings.

- A hearing aid evaluation test and a conformity test for either ear, or both ears, that:
  - is prescribed by a physician-specialist;
  - is performed following a medical hearing loss examination and an audiometric examination; and
  - is performed by a physician-specialist or audiologist or hearing aid specialist/dealer.
- The actual cost and dispensing fee for a hearing aid for either ear, or both ears. The hearing aid must be:
  - designed to be worn in the ear, behind the ear, or on the body;
  - prescribed by a physician-specialist, audiologist or hearing aid specialist/dealer based on the most recent audiometric examination and hearing aid evaluation test;
  - the make and model prescribed by the physician-specialist, audiologist, or hearing aid specialist/dealer; and
  - provided by a hearing aid specialist or dealer.

There is a plan maximum benefit, adjusted annually based on the Consumer Price Index (CPI), for a hearing aid for each ear during a thirty-six (36) month period. Contact MESSA for information about the contract limit.

Expenses not covered for hearing care include:

- an audiometric examination by an audiologist or hearing aid specialist/dealer that is not prescribed by a physician-specialist;
- hearing aids delivered more than sixty (60) days after coverage ended;
- the trial and testing of different makes and models of hearing aids when such testing is **not** supported by the results of the most recent audiometric examination;
- charges for "spare" hearing aids;
- replacement of hearing aids that are lost or broken, unless this benefit was not used for at least thirty-six (36) months;

- hearing aids that do not meet Food and Drug Administration and Federal Trade Commission requirements.

## Section 10: Exclusions and Limitations

The following exclusions and limitations apply to the MESSA Choices II program. These are in addition to limitations appearing elsewhere in this coverage 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 incurred because of war, declared or undeclared, or any act thereof; or for injury or sickness sustained or contracted in the armed forces of any country; or for services provided in a Veterans Administration Hospital for a covered person with military service-connected disability; or for services, supplies or treatments provided or covered under any governmental plan or law or which would have been furnished without cost in the absence of this coverage or for which the covered person has no legal obligation to pay. However, care and services are payable if federal laws require the government sponsored program to be secondary.
- clerical fees including fees for patient records
- custodial care or basic care that can be provided by someone other than a registered nurse or licensed practical nurse, and which is care provided primarily to assist the person in the activities of daily living
- dental care (except as previously specified) including repairs of supporting structures for partial or complete dentures, dental implants, extractions, extraction repairs, bite splints, braces and appliances and other dental work or treatment
- educational care and cognitive therapy
- eye examinations and eyeglasses or other corrective visual appliances except as specified elsewhere in this Certificate;
- 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 Section 7)

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

  However, because of ongoing medical research and technological advances, procedures that have been considered experimental may become generally accepted standard treatments. To be covered under this plan, these procedures must be recognized as a standard of care and be medically necessary for the illness or injury being treated.
- surgery for cosmetic or beautifying purposes, except for the correction of conditions resulting from an accidental injury or from an illness
- transplants (other than those previously specified) and all charges arising out of, or associated with, these transplants whether incurred prior to the transplant, at the time of the transplant or subsequent to the transplant
- transportation expenses (except as previously specified) including meals and lodging
- unless otherwise stated in this coverage booklet, any services, treatment, care or supplies provided before the effective date of this coverage, or after the date on which coverage ends, except hospital, skilled nursing facility or residential substance abuse facility services for inpatient admissions that began before, and extended beyond, the date coverage ends
- health care services provided by persons who are not legally qualified or licensed to provide such services
- anti-rejection drugs that do not have Food and Drug Administration approval
- items that are not considered directly related to travel, meals and lodging in conjunction with the initial surgery and hospitalization for a human organ transplant (examples include, but are not limited to, the following: clothing, personal hygiene and related services, car maintenance, babysitters or daycare services and entertainment)
- radiology procedures not directly related and necessary to diagnose the disease, illness, pregnancy or injury (such as an ultrasound solely to determine the gender of the fetus)
- self-administered, over-the-counter drugs
- 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 coverage booklet
- speech and language pathology services to treat chronic conditions, congenital or inherited speech abnormalities, developmental conditions or learning disabilities except for children
- 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.*

## Section 11: General Conditions of Your Coverage

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

### Contest

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

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

### Coordination of Benefits

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

The guidelines used to determine the primary plan are:

- a group plan or automobile no-fault insurance plan with no provision for the coordination of benefits is always primary; otherwise,
- the plan sponsored by the employer of the person receiving the treatment is primary
- If the claim is for a dependent child covered under two or more plans, the primary plan is that of the parent whose birthday anniversary falls earlier in the year. If the birthdates are identical, the plan that has covered the dependent the longest is primary. However, benefits for a child of divorced or separated spouses are determined in the following order:
  - plan of parent having financial responsibility as designated by court decree;
  - custodial parent's plan;
  - plan of the custodial parent's new spouse (if remarried)
  - plan of noncustodial parent.

- If the primary plan cannot be determined using the above guidelines, then the plan covering the person the longest is primary. The only exception to this rule is that if the coverage is through a member who is retired or laid off, and there is also coverage through a plan not involving a retired or laid off employee, the plan covering the person who is not a retired or laid off employee will be primary.

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

### Determination of Medical Necessity

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

### Experimental or Investigational Services

We do not pay for experimental or investigational drugs or services. Facility services and physician services, including diagnostic tests, which are related to experimental or investigational procedures, are also not payable.

The BCBSM medical director is responsible for determining whether the use of any service is experimental or investigational. The service may by determined to be experimental or investigational when there is:

- a written experimental or investigational plan by the attending provider or another provider studying the same service, or
- a written informed consent used by the treating provider in which the service is referred to as experimental, investigational or other than conventional or standard therapy, or
- an on-going clinical trial

The BCBSM medical director uses the following information in the evaluation process:

- scientific data such as controlled studies in peer review journals or medical literature
- information from the Blue Cross and Blue Shield Association or other local or national bodies
- information from local and national medical societies, other appropriate professional societies, organizations, committees or governmental bodies
- approval, when applicable, by the Food and Drug Administration, the Office of Health Technology Association and other governmental agencies
- accepted national standards of practice in the medical profession
- approval by the Institutional Review Board of the hospital or medical center

## Your Right To File An Internal Grievance And To Request An Independent External Review

Michigan Public Act 350, as amended by Public Act 516 of 1996 and Public Act 250 of 2000, provides an internal grievance procedure, including a managerial-level conference, if you believe that we have violated Section 402 or 403 of Public Act 350.

Public Act 251 of 2000 provides you with the right to request an external review from the Commissioner of Financial and Insurance Services if we have denied, reduced or terminated an admission, availability of care, continued stay or other health care service. Normally, you must exhaust our standard internal grievance procedure before you can request an external review.

### Internal Grievances

*Standard Internal Grievance Procedure*

Under the standard internal grievance procedure, we must provide you with our final written determination within 35 calendar days of our receipt of your written grievance. However, that timeframe may be suspended for any amount of time that you are permitted to take to file your grievance, and for a period of up to 10 days if we have not received information we have requested from a health care provider, for example your doctor or hospital. The standard internal grievance procedure is as follows:

- You or your authorized representative must send us a written statement explaining why you disagree with our determination on your request for benefits or payment.
  - Mail your written grievance to the address found in the top right hand corner of the first page of your Explanation of Benefits statement, or to the address contained in the letter we send you to notify you that we have not approved a benefit or service you are requesting.
  - We will respond to your grievance in writing. If you agree with our response, it becomes our final determination and the grievance ends.
- If you disagree with our response to your grievance, you may then request a managerial-level conference. You must request the conference in writing. Mail your request to:

  **Legal & Compliance Department**
  MESSA
  1475 Kendale Blvd., P.O. Box 2560
  East Lansing, MI 48826-2560

  You can ask that the conference be conducted in person or over the telephone. If in person, the conference can be held at our headquarters in Detroit or at a local customer service center. Our written proposed resolution will be our final determination regarding your grievance.
- If you disagree with our final determination, or if we fail to provide it to you within 35 days of the date we received your original written grievance, you may request an external review from the Michigan Commissioner of Financial and Insurance Services.

In addition to the information found above, you should also know:

- You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the standard internal grievance procedure.

- Although we have 35 days within which to give you our final determination, you have the right to allow us additional time if you wish.
- You may obtain copies of information relating to our denial, reduction, or termination of coverage for a health care service for a reasonable copying charge.

## Expedited Internal Grievance Procedure

If a physician substantiates orally or in writing that adhering to the timeframe for the standard internal grievance would jeopardize your life or health, or would seriously jeopardize your ability to regain maximum function, you may file a request for an expedited internal grievance only when you think that we have wrongfully denied, terminated, or reduced coverage for a health care service ***prior*** to your having received that health care service or if you believe we have failed to respond timely to a request for benefits or payment. The procedure is as follows:

- You may submit your expedited internal grievance request by telephone. The required physician's substantiation that your condition qualifies for an expedited grievance can also be submitted by telephone. **Call: 800.742.2328 (option 1)**.

  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 Commissioner.

In addition to the information found above, you should also know:

- You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the expedited internal grievance procedure.
- If our decision is communicated to you orally, we must provide you with written confirmation within two (2) business days.

## External Reviews

*Standard External Review Procedure*

Once you have exhausted our standard internal grievance procedure, you or your authorized representative has the right to request an external review from the Commissioner. The standard external review process is as follows:

- Within 60 days of the date you either received our final determination or should have received it, send a written request for an external review to the Commissioner.

Mail your request, including the required forms that we will supply to you to:

**OFIS Consumer Services**
P.O. Box 30220
Lansing, MI 48909-7720

- If your request for external review concerns a **medical issue**, and is otherwise found to be appropriate for external review, the Commissioner will assign an Independent Review Organization, consisting of independent clinical peer reviewers, to conduct the external review. you will have an opportunity to provide additional information to the Commissioner

within seven (7) days after you submit your request for an external review. We must provide documents and information considered in making our final determination to the Independent Review Organization within seven (7) business days after we receive notice of your request from the Commissioner.

The assigned Independent Review Organization will recommend within 14 days whether the Commissioner should uphold or reverse our determination. The Commissioner must decide within seven (7) business days whether or not to accept the recommendation and will notify you. The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent Review Act.

- If your request for external review is related to **non-medical issues**, and is other wise found to be appropriate for external review, the Commissioner's staff will conduct the external review.

  The Commissioner's staff will recommend whether the Commissioner should uphold or reverse our determination. The Commissioner will notify you of the decision, and the Commissioner's decision is your final administrative remedy under Public Act 350.

## Expedited External Review Procedure

If a physician substantiates orally in writing that you have a medical condition for which the timeframe for completion of an expedited internal grievance would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and if you have filed a request for an expedited internal grievance, you may request an expedited external review, from the Commissioner.

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

- Within 10 days of your receipt of our denial, termination, or reduction in coverage for a health care service, you or your authorized representative may request an expedited external review from the Commissioner.

  - To do so in writing, mail your request, including the required forms that we will supply to you to:

    **OFIS Consumer Services**
    Post Office Box 30220
    Lansing, MI 48909-7720

  - To do so by telephone, call the following toll free number: **1.877.999.6442**

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

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

## Release of Information

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

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

## Subrogation/Right of Recovery

From time to time, MESSA/BCBSM/BCS may pay claims for which another person or persons, insurance company or other organization (including the covered member's employer or any workers' disability or occupational disease act insurer) is responsible. In these cases, the covered member:

- Grants MESSA/BCBSM/BCS the covered member's right to recover from the responsible party to the extent of MESSA/BCBSM/BCS's payment. MESSA, BCBSM, and BCS have entered into an agreement assigning this right to recovery to MESSA.

- Grants MESSA/BCBSM/BCS a first priority security interest (meaning the right to be paid before any other person, including the covered member) from money recovered on all money that a covered member or a covered member's estate or beneficiaries recover in a verdict, judgment, settlement (regardless of whether the settlement is part of a legal action) or otherwise. Any part of the recovery that is used to pay attorneys' fees and costs will not be subject to MESSA/BCBSM/BCS's lien.

- Agrees to inform MESSA/BCBSM/BCS when the covered member (or a beneficiary) hires an attorney to represent the covered member or beneficiary with respect to a claim for recovery against a responsible party whether that claim is made through litigation or is asserted prior to litigation.

- Agrees to inform any attorney retained of MESSA/BCBSM/BCS's rights under this coverage booklet.

- Agrees to take whatever steps are necessary to assist MESSA/BCBSM/BCS in enforcing its right of recovery, including but not limited to, cooperating in trial preparation, discovery and by testifying in any civil action.

If an overpayment is made by MESSA/BCBSM/BCS for any reason, including but not limited to a payment under any workers' disability or occupational disease act or law, clerical error, or misstatement of fact, MESSA/BCBSM/BCS shall have the right to recover such overpayments from the covered member (or a beneficiary of the covered member's estate) or to deduct such amount of overpayment from future benefit payments.

### Time Limit for Legal Action

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

### What Laws Apply

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

## Section 12: How to File a Health Claim

Health care benefits provided by this plan are underwritten by BCBSM and BCS.

- **BCBSM Panel and Participating Provider**
  A hospital, doctor, pharmacy or other provider who contracts with BCBSM or who participates per claim to accept its payments as payment-in-full for covered services less any required copayments or deductibles. It allows the provider to bill BCBSM and to receive payment directly from BCBSM. Reimbursement for services provided by a participating provider is based on BCBSM's approved amount. All paperwork is completed by the provider.

*Note: Some nonpanel providers may be BCBSM participating providers.*

- **Nonparticipating Provider**
  A hospital, doctor, pharmacy or other provider that does not have a contract with BCBSM. However, a nonparticipating provider may participate on a per claim basis by agreeing to accept BCBSM's approved amount as payment-in-full, less any required deductibles and/or copayments.

If your provider does not agree to participate, covered services will be paid up to the approved amount as determined by MESSA. You will be responsible for any required deductible or copayment and any amount exceeding MESSA's payment determination.

If a hospital or physician does not complete a claim form, you will need to request an itemized statement/receipt and send these bills to MESSA. If written authorization is attached to the bill, MESSA will pay the provider; otherwise, payment will be sent to you.

Your itemized statement/receipt should contain the following information:

- member's name and contract number
- full name of patient and date of birth
- date of service
- type of service (type of procedure performed)
- individual charge(s)
- diagnosis
- provider's name, address, telephone number and tax-payer identification number

*Note: If you or your dependent(s) have coverage through another carrier who is primary (see "Coordination of Benefits" in section 11), 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.*

## Care Outside of Michigan

If you or a covered dependent receive treatment in an accredited non-Michigan hospital, just show your MESSA/BCBSM identification card. The hospital billing office will send the bill directly to MESSA or the local Blue Cross plan.

If you or a covered dependent receives any other type of service performed by a physician practicing outside of Michigan, the physician's billing office will either bill the local Blue Cross plan directly or provide you with an itemized statement or receipt. Send these itemized statements to MESSA. If written authorization is attached to the statement, MESSA will pay the provider; otherwise, payment will be sent to you.

## Additional Information

Certain eligible expenses for services, supplies or care not otherwise covered under the BCBSM coverage are covered under the group policy underwritten by BCS Life Insurance Company. These covered expenses include:

- Manipulations (above BCBSM approved amounts), modalities, and orthotics charged by a chiropractor;
- Outpatient physical therapy billed by a skilled nursing facility;
- Outpatient diabetic education programs approved by MESSA;
- Prescription medication (given in a doctor's office or hospital clinic, out-of-state charges, and member paid charges);
- Vision service;
- TMJ, excluding surgery, anesthesia and x-ray, but including MORA and follow-up treatment;
- Take home drugs, equipment and supplies from hospitals billed along with emergency room treatment, inpatient stay or outpatient scheduled surgery charges;
- Supplier's or supplier's charges for rental of equipment used to do pneumogram at home;
- Consultations with Christian Science Practitioners;
- Copay for physical therapy due to accidental injury;
- Copay on 24-hour observation stay in a participating facility;
- Amounts paid to non-participating providers in excess of BCBSM's approved amounts;

- Out-of-state inpatient bills more than one year old;
- MESSA covered charges that are exclusions in out-of-state Blue Cross plans;
- BCBSM advance payment plan copayments and deductibles;
- COB balances in inpatient out-of-state facilities;
- Hearing care services;
- Michigan MSW who is a member of the Academy of Certified Social Workers; and
- Services of nonpanel outpatient psychiatric care facilities and nonpanel substance abuse treatment programs.

## Section 13: How to File a Life and/or Accidental Death and Dismemberment Claim

### Life Claims

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

### AD&D Claims

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

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

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

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

- Connecticut General; or
- MESSA; or
- any other authorized representative of Connecticut General.

The notice must include sufficient information to identify you.

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

- the occurrence of the loss;
- the nature of the loss;
- the extent of the loss.

The proof of loss must be given within the time stated in "Proof of Loss" below.

*Proof of Loss* - Written proof of the loss must be given to Connecticut General within 90 days after:

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

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

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

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

Any part of the benefit for which there is no such beneficiary or terms in effect will be paid to your estate. Any other accrued benefits not paid at your death may, at the option of Connecticut General, be paid either to such beneficiary or your estate. Accidental dismemberment benefits will be payable to you.

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

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

*Legal Actions* - No one may sue for payment of a claim less than 60 days after proof of loss is furnished in accord with the terms of the policy. No one may bring suit more than three years after the date proof of loss is required by the policy.

*Time Limit on Certain Defenses* - A claim will not be denied nor will the validity of coverage be contested because of any statement with respect to insurability made by you while eligible for coverage under the policy, if:

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

*Change of Beneficiary* - You may change your beneficiary at any time; you do not need the consent of the beneficiary to make such change.

Contact MESSA Group Services with any life and/or AD&D claim questions you may have.

**Life and Accidental Death and Dismemberment Insurance**
Underwritten by
Connecticut General Life Insurance Company

**Medical Expense Benefits**
Underwritten by
Blue Cross Blue Shield of Michigan
*(an independent licensee of the Blue Cross and Blue Shield Association)*
and
BCS Life Insurance Company

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