

- 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 maximum benefit of \$1,250, adjusted annually based on the Consumer Price Index (CPI), for a hearing aid for each ear during a thirty-six (36) month period. In addition, an audiometric examination, a hearing aid evaluation, and a conformity test for each ear will be paid during a thirty-six (36) month period.

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 be 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

How to Appeal a Claim Denial

Written Complaint

If you do not agree with a claim denial, you may request a review. Your request must be in writing and may include additional facts or comments that support your position. In gathering information to submit with your request, you may obtain copies of pertinent documents if you pay a reasonable copying charge. In some cases, authorization may be needed for the release of confidential information, such as medical records.

Your request for review must be submitted within 90 days after receiving a notice of denial. Please send your request to MESSA Benefits Administration.

A decision will be made by MESSA/BCBSM normally within 30 days of MESSA's receipt of request for review or the date all information required of you is furnished, whichever date is later. The decision will be in writing and will specify the reason for MESSA's/BCBSM's decision.

Managerial-Level Conference

If you are dissatisfied with this decision, you may request a Managerial-Level Conference. The decision resulting from this conference will be rendered not later than 90 days after we receive your initial written request for a review.

If you are dissatisfied with the result of your Managerial-Level Conference, you may request an Informal Review and Determination by the Insurance Commissioner within 120 days of our decision.

Expedited Appeals

If a physician substantiates either orally or in writing that handling your complaint under the above time frames will acutely jeopardize your life, you are eligible for an expedited grievance procedure.

Under this procedure, you will receive an initial determination within 72 hours after your complaint is received. If you want a further review by MESSA/BCBSM, you must request it within three business days after our initial determination. We will give you a final decision within 30 days of the receipt of your request. If either our initial or final determination is made orally, we will provide a written confirmation to you not later than two business days after our oral determination.

If you are dissatisfied with the final determination of your expedited grievance, you may request an Informal Review and Determination by the Insurance Commissioner within 10 days of MESSA's/BCBSM's final decision.

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 by 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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