

Overview Comparison Between MESSA Choices/Choices II and Super Care

This is a brief summary of coverage. This is not a complete description of benefits.

Caution: If a category of coverage in which you are interested is not mentioned in this summary, do not assume that it is or is not a covered benefit.

Service	MESSA Choices/Choices II PPO		Super Care**
	In-Network*	Out-of-Network	
Deductibles and Dollar Maximums	Individual / Family	Individual / Family	Individual / Family
Deductible - Per calendar year	None With deductible carryover	\$250 / \$500 No carryover provision	\$50 / \$100 With deductible carryover
Maximum Out-of-Pocket	None - due to minimal copayments	\$2,000 / \$4,000 per calendar year Amounts not covered by stop loss include: <ul style="list-style-type: none"> ▪ Deductible amounts ▪ Charges exceeding approved amount ▪ Non-covered charges ▪ Rx copayments ▪ Private duty nursing copayments 	100% coverage after family co-insurance payments reach \$1,000 in a calendar year Amounts not included: <ul style="list-style-type: none"> ▪ Deductible amounts ▪ Charges exceeding approved amount ▪ Non-covered charges ▪ Rx copayments
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Preventive Services			
Preventive Care - List of covered screenings as recommended by the U.S. Preventive Services Task Force	100% - No deductible, No copayment	Not covered	100% of the approved amount - No deductible, No copayment
Pediatric Preventive Care	100% - No deductible, No copayment	Not covered	100% of the approved amount - No deductible, No copayment
Childhood Immunizations — age 0 - 6*	100% - No deductible, No copayment	Not covered	100% of the approved amount - No deductible, No copayment
Childhood Immunizations — age 7 - 18*	100% - No deductible, No copayment	Not covered	100% of the approved amount - No deductible, No copayment
Adult Immunizations*	100% - No deductible, No copayment	Not covered	100% of the approved amount - No deductible, No copayment
<i>*Immunizations provided by a Public Health Department or at a MESSA-sponsored event are considered in-network</i>			

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Preventive Services (continued)			
Routine Mammography (one screening mammography per member per year)	100% - No deductible	80% of the approved amount after Out-of-network deductible	100% of the approved amount
Physician Office Services			
Office Visits	\$5 copayment	80% of the approved amount after Out-of-network deductible	90% of the approved amount after deductible. 100% of the approved amount (within 90 days) for accidental injury.
Emergency Medical Care			
Hospital Emergency Room (approved diagnosis)	\$25 copayment waived if admitted or for accidental injury	\$25 copayment after Out-of-network deductible, waived if admitted or for accidental injury	<ul style="list-style-type: none"> ▪ 100% of the approved amount (within 90 days) for accidental injury ▪ 90% of the approved amount, after deductible ▪ 90% of the approved amount for life-threatening emergency care
Urgent Care Center	\$10 copayment waived if admitted or for accidental injury	80% of the approved amount after Out-of-network deductible; 100% of the approved amount for initial exam for accidental/medical emergency.	
Ambulance Services	100%	100% of the approved amount	90% of the approved amount after deductible
Diagnostic Services			
Laboratory, Pathology & Diagnostic Tests, X-Rays, Radiation Therapy and Chemotherapy	100%	80% of the approved amount after Out-of-network deductible	100% of the approved amount
Maternity Services			
Prenatal and Post-natal Care, Delivery and Nursery Care (includes care by a certified nurse midwife)	100%	80% of the approved amount after Out-of-network deductible	100% of the approved amount
Hospital Care***			
Semi-private Room, In-patient Physician Care, In-patient Consultations, General Nursing Care, Hospital Services and Supplies	100%	80% of the approved amount after Out-of-network deductible	100% of the approved amount for: <ul style="list-style-type: none"> ▪ Semi-private room ▪ Medically necessary private room 100% of the approved semi-private room rate plus \$5.00 per day for private room (not medically necessary)
Alternatives to Hospital Care			
Skilled Nursing Care (Custodial or domiciliary care <i>not</i> covered)	100% up to 120 days per calendar year	100% of the approved amount up to 120 days per calendar year	90% of the approved amount after deductible
Hospice Care	100%	100% of the approved amount	100% of the approved amount

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Alternatives to Hospice Care (continued)			
Home Health Care	100% of the approved amount	100% of the approved amount after Out-of-network deductible	100% of the approved amount
Surgical Services In all categories, percentages may vary if multiple surgeries are performed on the same day			
Surgery - includes related surgical services	100%	80% of the approved amount after Out-of-network deductible	100% of the approved amount
Transplants			
Specified Human Organ Transplants	100% - Must be performed in a BCBSM-designated facility to be covered.		100% - Must be performed in a BCBSM-designated facility
Bone Marrow Transplants and Kidney, Cornea, Skin	100%	80% of the approved amount after Out-of-network deductible	100% of the approved amount
Mental Health and Substance Abuse Care			
Inpatient Mental Health and Substance Abuse***	100%	80% of the approved amount after Out-of-network deductible	100% of the approved amount
Outpatient Mental Health and Substance Abuse	\$5 copayment	80% of the approved amount after Out-of-network deductible	90% of the approved amount after deductible.
Other Services			
Allergy Testing and Therapy	100% of the approved amount	80% of the approved amount after Out-of-network deductible	100% of the approved amount for testing after deductible; 90% of the approved amount for therapy after deductible
Chiropractic Services	<ul style="list-style-type: none"> ▪ 100% ▪ Up to 38 visits per member, per calendar year combined with out-of-network 	<ul style="list-style-type: none"> ▪ 80% of the approved amount after Out-of-network deductible ▪ Up to 38 visits per member, per calendar year combined with in-network 	90% of the approved amount after deductible
Outpatient Physical, Speech and Occupational Therapy	<ul style="list-style-type: none"> ▪ 100% ▪ Up to 60 visits per calendar year (includes all three types of therapy and any out-of-network therapy visits) 	<ul style="list-style-type: none"> ▪ 80% of the approved amount after Out-of-network deductible when billed by approved provider type ▪ Up to 60 visits per calendar year (includes all three types of therapy and any in-network therapy visits) 	90% of the approved amount, after deductible
Durable Medical Equipment, Prosthetic and Orthotic Appliances	100%	100% of the approved amount	90% of the approved amount after deductible
Private Duty Nursing	90%	90% of the approved amount after Out-of-network deductible	90% of the approved amount after deductible

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Other Services (continued)			
Hearing Aids - audiometric exam, hearing aid evaluation, conformity test	100% up to the scheduled amount every 36 months	100% up to the scheduled amount every 36 months	Not covered - unless due to accidental injury
Medical Case Management	Included	Included	Included
Healthy Expectations - Prenatal information Program, NurseLine - Health Information Helpline	Included	Included	Included
Group Prescription Drug Riders****			
\$10 / \$20 Dispensed at a Pharmacy	Copayment \$10 generic / \$20 brand name / generic requirement	75% of the approved amount, minus the copayment	<ul style="list-style-type: none"> ▪ Copayment \$10 generic / \$20 brand name ▪ 75% of the approved amount, minus the copayment, for non-participating pharmacies
Mail Order Service / 90-Day Retail/Maintenance Network***** <i>(included in both alternative plans above)</i>	Two copayments for a 90-day supply	Not included	Two copayments for a 90-day supply

* **Choices/Choices II PPO** - requires you to select or be referred by a doctor in the PPO Network to receive in-network benefits. All services must be medically necessary and are subject to the Coordination of Benefits provision.

** **Super Care** - You may elect to visit any physician for treatment. Participating providers bill MESSA/BCBSM directly for covered services. Participating providers are reimbursed at 90% or 100% of a previously agreed upon BCBSM approved amount. Patients are only responsible for paying any applicable copayment or deductible. When a member chooses to see a non-participating provider for covered services, MESSA reimburses the member or the provider 90% or 100% of the MESSA/BCBSM maximum approved amount. Non-participating providers often charge patients additional out-of-pocket fees. Patients are responsible for all fees over and above the maximum approved amount.

*** **All hospital stays are subject to pre-admission review.** Network and participating hospitals take care of this requirement for you.

**** **For the \$10 / \$20 drug program** if a generic is available but you choose a brand name drug, you will pay the brand name copayment PLUS the difference between the BCBSM-approved amount and the retail cost of the drug. This applies to both retail and mail order prescriptions. MESSA's exclusive Mail-Order provider is Medco.

***** **Payment will be made to a 90-Day Retail/Maintenance Network pharmacy for up to a 30-day supply for a single copayment and for an 84-90 day supply for a double copayment.** There is no coverage for a 35-83 day supply under the 90-Day Retail/Maintenance Network program.