

Overview Comparison Between MESSA Choices II and Super Care 1 2003 Revision

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 II PPO In-Network	MESSA Choices II PPO Out-of-Network	Super Care 1 2003 Revision*
Deductible, Co-payments and Dollar Maximums			
Deductible	None	\$250 individual, \$500 family per calendar year	\$0; \$50/\$100; \$100/\$200 per calendar year
Maximum Out-of-Pocket	None	100% coverage after co-insurance payments reach \$2,000 individual, \$4,000 family in a calendar year. Amounts not included: <ul style="list-style-type: none"> ■ Deductible amounts ■ Charges exceeding approved amount ■ Uncovered charges ■ Rx co-payments ■ Private duty nursing co-pays 	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 ■ Uncovered charges ■ Rx co-payments
Lifetime Maximum	Unlimited for all covered services and as noted below for individual services	Unlimited for all covered services and as noted below for individual services	Unlimited
Preventive Services			
Health Maintenance Exam <small>(Includes routine lab and radiology)</small>	100% of the approved amount, one per calendar year	Not covered	Not covered
Annual Gynecological Exam and Pap Smear	100% of the approved amount, one per calendar year	Not covered	100% of the approved amount, one per calendar year
Well-Baby, Child Care, and Childhood Immunizations	100% of the approved amount 6 visits per year through age 1 2 visits per year - ages 2 and 3 1 visit per year age 4 through 15	Not covered	Not covered
Cancer & Blood Screening Tests, such as Fecal Occult, PSA & Sigmoidoscopy <small>(Includes Colonoscopy)</small>	100% of the approved amount, one per calendar year, age and frequency restrictions may apply	Not covered	100% of the approved amount for medical necessity or cancer screening, age and frequency restrictions may apply
Routine Mammography	100% of the approved amount, one baseline between ages 35-40. One per calendar year over age 40.	80% of approved amount after deductible; one baseline between ages 35-40. One per calendar year over age 40.	100% of the approved amount, one baseline between ages 35-39. One per calendar year over age 40.

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Physician Office Services			
Office Visits and Consultations	\$5 co-payment	80% of the approved amount, after deductible	90% of the approved amount, after deductible
Outpatient and Home Visits	100% of the approved amount	80% of the approved amount, after deductible	90% of the approved amount, after deductible
Emergency Medical Care			
Hospital Emergency Room	\$25 co-payment, waived if admitted or for accidental injury	\$25 co-payment, waived if admitted or for accidental injury	100% for accident/injury; 90% for emergency life-threatening illness; 90% after deductible for illness
Urgent Care Center	\$10 co-payment (waived if emergency or accidental injury)	80% of the approved amount, after deductible	100% for accident/injury; 90% for emergency life-threatening illness; 90% after deductible for illness
Ambulance Services	100% of the approved amount	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% of the approved amount	80% of the approved amount, after deductible	100% of the approved amount
Maternity Services Provided By A Physician			
Prenatal and Post-natal Care, Delivery and Nursery Care	100% of the approved amount	80% of the approved amount, after 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% of the approved amount	80% of the approved amount, after deductible	100% for private and semi-private room when medically necessary. Private room when not medically necessary is paid at semi-private rate plus \$5 per day. Pre-admission review required.

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Alternatives to Hospital Care			
Skilled Nursing Care	100% of the approved amount 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% of the approved amount, limited to the lifetime maximum which is adjusted annually	100% of the approved amount, limited to the lifetime maximum which is adjusted annually	100% of the approved amount up to an annual maximum (contact MESSA for current amount)
Home Health Care	100% of the approved amount	100% of the approved amount	100% of the approved amount
Surgical Services			
Surgery - includes related surgical services	100% of the approved amount	80% of the approved amount, after deductible	100% of the approved amount
Transplants			
Specified Human Organ <small>(Must be pre-approved at designated facilities)</small>	100% of the approved amount, up to \$1 million maximum	80% of the approved amount, up to \$1 million	100% of the approved amount, up to \$1 million
Bone Marrow Transplants and Kidney, Cornea, Skin	100% of the approved amount	Covered after deductible	100% of the approved amount
Mental Health and Substance Abuse Care			
Inpatient Mental Health and Substance Abuse	100% unlimited days; pre-authorization is required	80% of the approved amount after deductible; pre-authorization is required	100% of the approved amount
Outpatient Mental Health and Substance Abuse	90% of the approved amount, annual 50 visit maximum combined with any out-of-network visits	80% of the approved amount after deductible; annual 50 visit maximum combined with any in-network visits	90% of the approved amount after deductible; 50 visits per person annually
Other Services			
Allergy Testing and Therapy	100% of the approved amount	80% of the approved amount, after deductible	90% of the approved amount, after deductible
Chiropractic Services	100% of the approved amount, up to 38 visits per calendar year	80% of the approved amount, after deductible; up to 38 visits per calendar year	90% of the approved amount, after deductible

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Other Services (continued)			
Outpatient Physical, Speech and Occupational Therapy	100% of the approved amount, up to a combined maximum of 60 visits per calendar year	80% of the approved amount, after deductible, up to a combined maximum of 60 visits per calendar year	90% of the approved amount, after deductible
Durable Medical Equipment, Prosthetic and Orthotic Appliances	100% of the approved amount	100% of the approved amount	90% of the approved amount, after deductible
Private Duty Nursing	90% of the approved amount	90% of the approved amount	90% of the approved amount, after deductible
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	None
Medical Case Management	Included	Included	Included
Healthy Expectations - Prenatal Information Program, NurseLine - Health Information Helpline	Included	Included	Included
Prescription Drugs			
Purchased at a Pharmacy	Co-payment: \$5 generic/\$10 brand name	75% of the approved amount, minus the co-payment	\$0.50 or \$2 co-pay - participating pharmacies, 75% of approved amount minus the co-payment at non-participating pharmacies or Same Rx program as Choices II
Mail Service	\$2 co-payment	Not covered	\$0 or \$2 co-payment

***Super Care 1** - 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 co-payment or deductible. When a member chooses to see a non-participating provider for covered services, MESSA reimburses the member or the provider based on 90% or 100% of a predetermined MESSA/BCS maximum approved amount. Non-participating providers often charge patients additional out-of-pocket fees. Patients are responsible for all fees over and above the predetermined reimbursement.

Choices II PPO - requires you to select a doctor in the PPO Network to receive in-network benefits.

