OVERVIEW OF MESSA BENEFITS

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 PPO In-Network	MESSA Choices PPO Out-of-Network	Super Care 12003 Revised*
DEDUCTIBLE, COPAYMENTS 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 - due to minimal co-pays	$2,000/$4,000 per calendar year Amounts not covered by stop loss include: Deductible amounts, charges exceeding R&C, uncovered charges, Rx co-payments, mental health/substance abuse and private duty nursing co pays.	100% coverage after family coinsurance payments reach $1,000 in a calendar year (not including deductible amounts, charges exceeding maximum amounts, uncovered charges, and Rx co- pays)
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	100%, one per calendar_year	Not covered	Not covered
Annual Gynecological Exam	100%, one per calendar year	Not covered	100%
Pap Smear	100%, one per calendar year	Not covered	100%, one per calendar year
Well-Baby and Child Care	100% 6 visits per year through age 1 2 visits per year - ages 2 and 3	Not covered	Not covered

	1 visit per year age 4 through 15		
Immunizations	100% to age 16	Not covered	Not covered
Fecal Occult Blood screening	100%, one per calendar year	Not covered	100% for medical necessity or cancer screening
Flexible Sigmoidoscopy Exam	100%, one per calendar year	Not covered	100% - 1 every 3-5 years following 2 negative exams 1 year apart
Prostate Specific Antigen (PSA) screening	100%, one per calendar year	Not covered	100% for medical necessity or cancer screening
Routine Mammography	100%, one baseline between ages 35-40. One per calendar year over age 40	80% of R&C after deductible; one baseline between ages 35-40. One per calendar year over age 40	100% one baseline between ages 35-40. Every 2 years ages 40-49; every year age 50+.
PHYSICIAN OFFICE SERVICES			
Office Visits	$5 co-payment	80% of R&C after deductible	90%, after deductible
Outpatient and Home Visits	100%	80% of R&C after deductible	90%, after deductible
Office Consultations	$5 co-payment	80% of R&C after deductible	90%, 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
Ambulance Services	100%	100% R&C	90%, after deductible
Urgent Care Center	$10 co-payment (waived if emergency or accidental injury)	80% of R&C after deductible	100% for accident/injury; 90% emergency life threatening illness; 90 % after deductible for illness
DIAGNOSTIC SERVICES			
Laboratory and Pathology Tests	100%	80% of R&C after deductible	100%

Diagnostic Tests and X-Rays	100%	80% of R&C after deductible	100%
Radiation Therapy	100%	80% of R&C after deductible	100%
MATERNITY SERVICES PROVIDED BY A PHYSICIAN			
Prenatal and Post-natal Care	100%	80% of R&C after deductible	100%
Delivery and Nurse Care	100%	80% of R&C after deductible	100%
HOSPITAL CARE			
Semi-private Room, Inpatient Physician Care, General Nursing Care, Hospital Services & Supplies	100%	80% of R&C 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.
Inpatient Consultations	100%	80% of R&C after deductible	100%
Chemotherapy/Radiation	100%	80% of R&C after deductible	100%
Alternatives to Hospital Care			
Skilled Nursing Care	100% up to 120 days per calendar year	100% of R&C, up to 120 days per calendar year	90% after deductible
Hospice Care	100%, limited to the lifetime maximum which is adjusted annually	100% of R&C, 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%	100% of R&C	100%
SURGICAL SERVICES			
Surgery- includes related surgical services	100%	80% of R&C after deductible	100%
Voluntary Sterilization	100%	80% of R&C after deductible	100%
TRANSPLANTS			
Specified Human Organ	100%, up to $1 million maximum	80% of R&C, up to $1 million	100% up to $1 million per

Transplants (liver, heart, lung, pancreas, heart/lung, small bowel/liver) must be pre-approved at designated facilities.	per transplant type	maximum per transplant type	transplant type
Bone marrow transplants	100%	Covered after deductible	100%
Kidney, Cornea, Skin	100%	Covered after deductible	100%
MENTAL HEALTH AND SUBSTANCE ABUSE CARE			
Inpatient Mental Heath and Substance Abuse Care	100% unlimited days; pre-authorization is required	70% of R&C after deductible; pre-authorization is required	100%
Outpatient Mental Health and Substance Abuse	90%	50% of R&C after deductible; combined annual 30 visit maximum for out-of-network	90% after deductible; 50 visits per person annually
OTHER SERVICES			
Allergy testing and Therapy	100%	80% of R&C after deductible	90% after deductible
Chiropractic Services	100%, up to 38 visits per calendar year	80% of R&C after deductible; up to 38 visits per calendar year	90% after deductible
Outpatient Physical, Speech and Occupational Therapy	100%, up to a combined maximum of 60 visits per calendar year	80% of R&C after deductible, up to a combined maximum of 60 visits per calendar year	90% after deductible
Durable Medical Equipment	100%	100% of R&C	90% after deductible
Prosthetic and Orthotic Appliances	100%	100% of R&C	90% after deductible
Private Duty Nursing	90%	90% of R&C	90% 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	Included	Included	Included
NurseLine - Health Information Hel line	Included	Included	Included

PRESCRIPTION DRUGS			
Purchased at Pharmacy	Co-payment: $5 generic/$10 brand name Generic will be dispensed unless written DAW; or no Class A generic available. For certain conditions, no substitutions.	75% of the approved amount, minus the co-payment	$.50 or $2 co pay - no networks or same Rx program as Choices: $5/$10 Rx in-Network 75% out-of-Network
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 copayment 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 PPO - requires you to select a doctor in the PPO Network to receive in-network benefits