1	SET SEG	MESSA	MESSA	Blue Cross Blue Shield
2	DISCLAIMER: This document is a summary of certain plan features. It should not be interpreted as a complete comparison of the products represented.	**Choices II**	**ABC Plan 1**	**Simply Blue HSA $1300/$2600**
3	Summary	In Network	In Network	In Network
4	Deductible 1P	$500	$1,300	$1,300
5	Deductible 2P/FF	$1,000	$2,600	$2,600
6	Preventive Care Coverage	100%	100%	100%
7	Office Visit Coverage	$20 deductible may apply	100% after deductible	100% after deductible
8	Hospital Coverage After Deductible	100%	100%	100%
9	Surgical Coverage After Deductible	100%	100%	100%
10	Coinsurance Maximums - 1P			
11	Coinsurance Maximums - 2P/FF			
12	Out of Pocket Maximum- 1P	$1,500	$2,300	$2,250
13	Out of Pocket Maximum- 2P/FF	$3,000	$4,600	$4,500
14	Lifetime Maximum Benefit	None	None	None
15	Rx Coverage	Saver Rx	ABC Rx	$10/$40/$80 after deductible
16				
17	Detailed Benefits-at-a-Glance			
18	Preventive Care Services	In Network	In Network	In Network
19	Preventive Care Limit	Unlimited	Unlimited	Unlimited
20	Health Maintenance Exam – includes chest X-ray, EKG, and select lab procedures	Covered – 100%, one per calendar year	Covered – 100%, one per calendar year	Covered – 100%, one per calendar year
21	Annual Gynecological Exam	Covered – 100%, one per calendar year	Covered – 100%, one per calendar year	Covered – 100%, one per calendar year
22	Pap Smear Screening	Covered – 100%, one per calendar year	Covered – 100%, one per calendar year	Covered – 100%, one per calendar year
23	Well-Baby and Child Care	Covered – 100%	Covered – 100%	Covered – 100%
24	Immunizations	Covered – 100%	Covered – 100%	Covered – 100%
25	Fecal Occult Blood Screening	Covered – 100%, one per calendar year	Covered – 100%, one per calendar year	Covered – 100%, one per calendar year
26	Flexible Sigmoidoscopy Exam	Covered – 100%, one per calendar year	Covered – 100%, one per calendar year	Covered – 100%, one per calendar year
27	Prostate Specific Antigen (PSA) Screening	Covered – 100%, one per calendar year	Covered – 100%, one per calendar year	Covered – 100%, one per calendar year
28				
29	Mammography	In Network	In Network	In Network
30 31	Routine Mammography	Covered 100%	Covered 100%	Covered 100%
32				
33	Physician Office Services	In Network	In Network	In Network
34	Primary Care Physician (PCP) Requirement	No Requirement	No Requirement	No Requirement
35	Out-of-Network Referral Treatment	Services covered at 80% after OON deductible	Services covered at 80% after OON deductible	Services covered at 80% after OON deductible
36	Office Visits	$20 deductible may apply	100% after deductible	100% after deductible
37	Specialist Copay	$20 deductible may apply	100% after deductible	100% after deductible
38	Outpatient and Home Visits	$20 deductible may apply	100% after deductible	100% after deductible
39	Office Consultations	$20 deductible may apply	100% after deductible	100% after deductible
40				
41	Emergency Medical Care	In Network	In Network	In Network
42	Hospital Emergency Room	$50 deductible may apply	100% after deductible	100% after deductible
43	Urgent Care Visits	$25 deductible may apply	100% after deductible	100% after deductible

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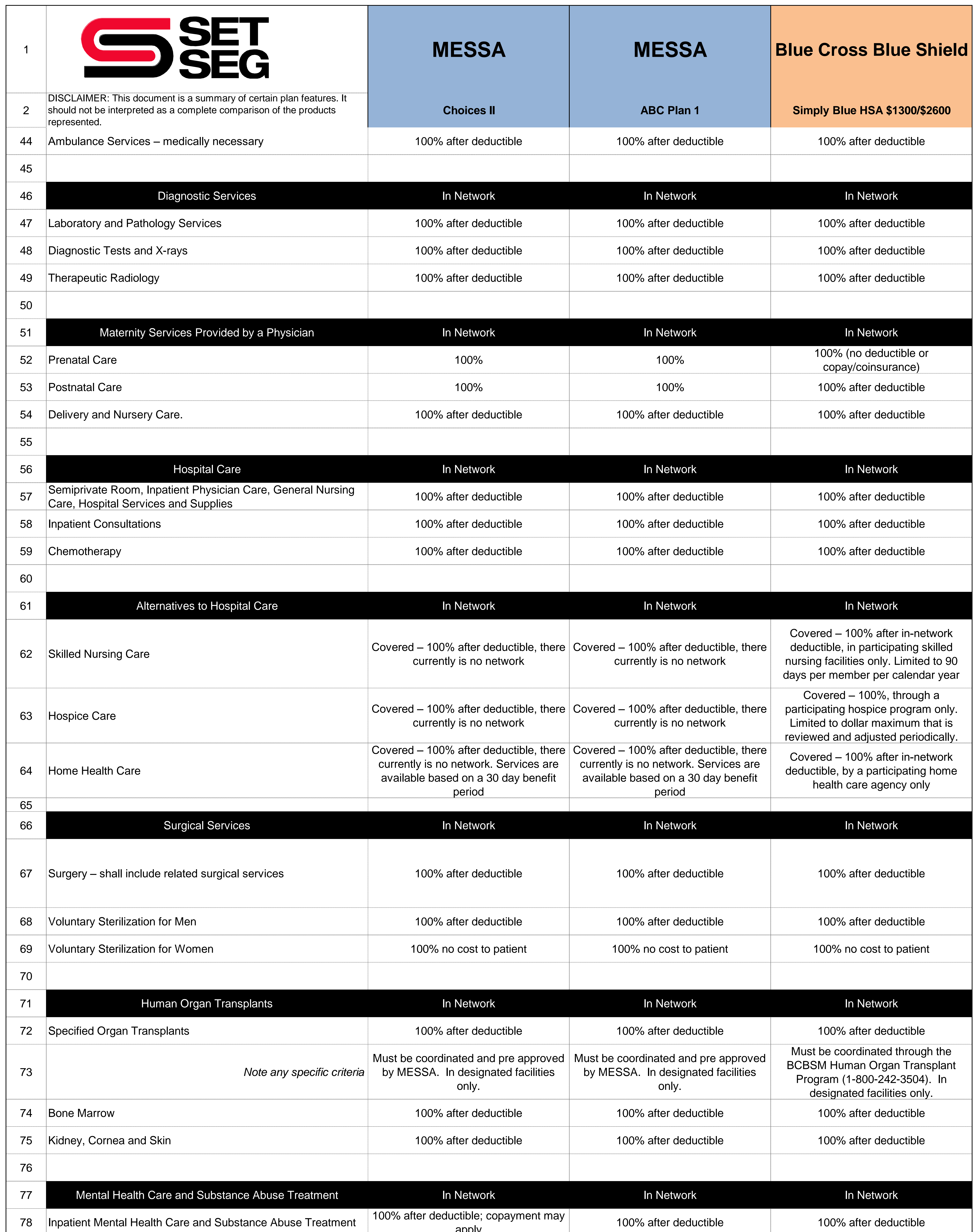

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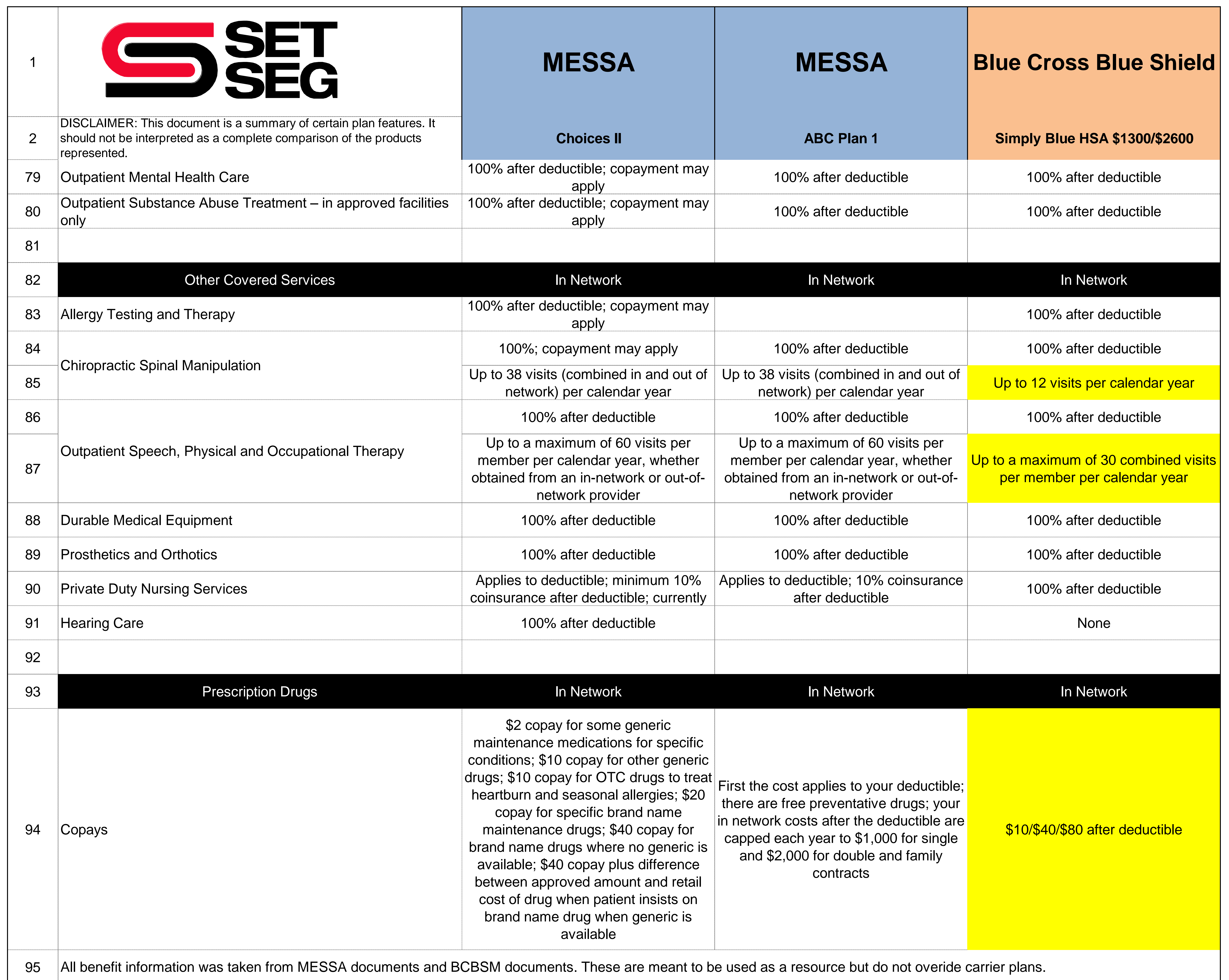
44	Ambulance Services – medically necessary	100% after deductible	100% after deductible	100% after deductible
45				
46	Diagnostic Services	In Network	In Network	In Network
47	Laboratory and Pathology Services	100% after deductible	100% after deductible	100% after deductible
48	Diagnostic Tests and X-rays	100% after deductible	100% after deductible	100% after deductible
49	Therapeutic Radiology	100% after deductible	100% after deductible	100% after deductible
50				
51	Maternity Services Provided by a Physician	In Network	In Network	In Network
52	Prenatal Care	100%	100%	100% (no deductible or copay/coinsurance)
53	Postnatal Care	100%	100%	100% after deductible
54	Delivery and Nursery Care.	100% after deductible	100% after deductible	100% after deductible
55				
56	Hospital Care	In Network	In Network	In Network
57	Semiprivate Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	100% after deductible	100% after deductible	100% after deductible
58	Inpatient Consultations	100% after deductible	100% after deductible	100% after deductible
59	Chemotherapy	100% after deductible	100% after deductible	100% after deductible
60				
61	Alternatives to Hospital Care	In Network	In Network	In Network
62	Skilled Nursing Care	Covered – 100% after deductible, there currently is no network	Covered – 100% after deductible, there currently is no network	Covered – 100% after in-network deductible, in participating skilled nursing facilities only. Limited to 90 days per member per calendar year
63	Hospice Care	Covered – 100% after deductible, there currently is no network	Covered – 100% after deductible, there currently is no network	Covered – 100%, through a participating hospice program only. Limited to dollar maximum that is reviewed and adjusted periodically.
64	Home Health Care	Covered – 100% after deductible, there currently is no network. Services are available based on a 30 day benefit period	Covered – 100% after deductible, there currently is no network. Services are available based on a 30 day benefit period	Covered – 100% after in-network deductible, by a participating home health care agency only
65				
66	Surgical Services	In Network	In Network	In Network
67	Surgery – shall include related surgical services	100% after deductible	100% after deductible	100% after deductible
68	Voluntary Sterilization for Men	100% after deductible	100% after deductible	100% after deductible
69	Voluntary Sterilization for Women	100% no cost to patient	100% no cost to patient	100% no cost to patient
70				
71	Human Organ Transplants	In Network	In Network	In Network
72	Specified Organ Transplants	100% after deductible	100% after deductible	100% after deductible
73	*Note any specific criteria*	Must be coordinated and pre approved by MESSA. In designated facilities only.	Must be coordinated and pre approved by MESSA. In designated facilities only.	Must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504). In designated facilities only.
74	Bone Marrow	100% after deductible	100% after deductible	100% after deductible
75	Kidney, Cornea and Skin	100% after deductible	100% after deductible	100% after deductible
76				
77	Mental Health Care and Substance Abuse Treatment	In Network	In Network	In Network
78	Inpatient Mental Health Care and Substance Abuse Treatment	100% after deductible; copayment may apply	100% after deductible	100% after deductible



		MESSA	MESSA	Blue Cross Blue Shield
1	SET SEG			
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79	Outpatient Mental Health Care	100% after deductible; copayment may apply	100% after deductible	100% after deductible
80	Outpatient Substance Abuse Treatment – in approved facilities only	100% after deductible; copayment may apply	100% after deductible	100% after deductible
81				
82	Other Covered Services	In Network	In Network	In Network
83	Allergy Testing and Therapy	100% after deductible; copayment may apply		100% after deductible
84	Chiropractic Spinal Manipulation	100%; copayment may apply	100% after deductible	100% after deductible
85		Up to 38 visits (combined in and out of network) per calendar year	Up to 38 visits (combined in and out of network) per calendar year	Up to 12 visits per calendar year
86	Outpatient Speech, Physical and Occupational Therapy	100% after deductible	100% after deductible	100% after deductible
87		Up to a maximum of 60 visits per member per calendar year, whether obtained from an in-network or out-of-network provider	Up to a maximum of 60 visits per member per calendar year, whether obtained from an in-network or out-of-network provider	Up to a maximum of 30 combined visits per member per calendar year
88	Durable Medical Equipment	100% after deductible	100% after deductible	100% after deductible
89	Prosthetics and Orthotics	100% after deductible	100% after deductible	100% after deductible
90	Private Duty Nursing Services	Applies to deductible; minimum 10% coinsurance after deductible; currently	Applies to deductible; 10% coinsurance after deductible	100% after deductible
91	Hearing Care	100% after deductible		None
92				
93	Prescription Drugs	In Network	In Network	In Network
94	Copays	$2 copay for some generic maintenance medications for specific conditions; $10 copay for other generic drugs; $10 copay for OTC drugs to treat heartburn and seasonal allergies; $20 copay for specific brand name maintenance drugs; $40 copay for brand name drugs where no generic is available; $40 copay plus difference between approved amount and retail cost of drug when patient insists on brand name drug when generic is available	First the cost applies to your deductible; there are free preventative drugs; your in network costs after the deductible are capped each year to $1,000 for single and $2,000 for double and family contracts	$10/$40/$80 after deductible
95	All benefit information was taken from MESSA documents and BCBSM documents. These are meant to be used as a resource but do not overide carrier plans.			

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