

## Office Personnel - Overview Comparison Between MESSA Choices II In-Network and Out-of-Network

This is a brief summary of coverage and 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 – (After Deductible)	MESSA CHOICES II PPO OUT-OF-NETWORK - (After Deductible)
	Deductible, Co-payments and Dollar Maximums	
Deductible	\$100 per person/\$200 per family in a calendar year	\$250 per person/\$500 per family in a calendar year
Maximum Out-of-Pocket	None – due to minimal co-payments and 100% coverage for most services	\$2,000 per person/ \$4,000 family in a calendar year.
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
Type of Service		
<b>Office Visits</b>	In-Network	Out-of-Network
<b>Prescription Drug Coverage</b> (mail order available)	\$20 co-payment	80% of the approved amount
<b>Inpatient Hospital</b>	\$10 Generic/\$20 Brand co-payment	75% minus the co-payment
<ul style="list-style-type: none"> <li>Semi-private room and board (includes supplies and services)</li> <li>Physician charges</li> </ul>	100%	80% of the approved amount
<b>Surgical Services</b> Includes: surgeon, assistant surgeon and anesthesiologist charges	100%	80% of the approved amount
<b>Hospital Emergency Room (ER)</b> Co-payment waived if admitted or due to accidental injury	\$50 co-payment	\$50 co-payment
<ul style="list-style-type: none"> <li>Hospital Charges</li> <li>ER Physician Charges</li> </ul>	100%	80% of the approved amount
<b>Urgent Care</b> – Co-payment waived if services are required to treat a medical emergency or accidental injury	\$25 co-payment	80% of the approved amount
<b>Allergy Testing &amp; Therapy</b>	100%	80% of the approved amount
<b>Chiropractic Services including Modalities</b> Up to 38 visits (combination of in-network and out of network visits) per calendar year	100%	80% of the approved amount
<b>Diagnostic Lab &amp; X-Ray</b>	100%	80% of the approved amount
<b>Radiation &amp; Chemotherapy</b>	100%	80% of the approved amount

SERVICE	MESSA CHOICES II PPO IN-NETWORK	MESSA CHOICES II PPO OUT-OF-NETWORK
<p><b>Preventive Care</b></p> <ul style="list-style-type: none"> <li>Well baby and well child care visits: <ul style="list-style-type: none"> <li>*6 visits from birth through 12 months</li> <li>*6 visits from 13 months through 23 months</li> <li>*2 visits from 24 months through 35 months</li> <li>*2 visits from 36 months through 47 months</li> <li>*1 visit per birth year for children 40 months through age 15</li> </ul> </li> <li>Childhood and Adult Immunizations – As recommended by the Advisory Committee on Immunization Practices and the American Academy of Pediatrics</li> <li>Cancer Screenings</li> <li>Health Maintenance Exams – age 16 through adult, 1 per calendar year</li> </ul>	<p>100% No deductible  (Adult immunizations Are covered)</p>	<p>Not covered (except for mammograms)</p>
<p><b>Additional Covered Services</b></p> <ul style="list-style-type: none"> <li>Medical Supplies and Equipment</li> <li>Ambulance</li> <li>Hearing Care (<i>plan limits apply</i>)</li> <li>Skilled Nursing Facility</li> <li>Hospice</li> <li>Home Health Care</li> <li>Human Organ Transplant – when authorized and performed at an approved facility(<i>plan limits apply</i>)</li> </ul>	<p>100%</p>	<p>100% of the approved amount* In-network deductible applies when there is no network for services</p>
<p><b>Mental Health and Substance Abuse</b></p> <p><b>Outpatient Care</b></p> <ul style="list-style-type: none"> <li>Mental health care – combined limit of 50 in-network and out-of-network visits per member, per calendar year</li> <li>Substance abuse treatment – care must be provided in a licensed substance abuse facility</li> </ul>	<p>90%</p>	<p>80% of the approved amount</p>
<p><b>Mental Health and Substance Abuse</b></p> <p>Inpatient – Pre-authorization required</p>	<p>100%</p>	<p>80% of the approved amount</p>
<p><b>Outpatient Physical and Speech Therapy</b></p> <p>Up to a combined benefit maximum of 60 visits per member per calendar year, whether obtained from an in-network or out-of-network provider</p>	<p>100%</p>	<p>80% of the approved amount</p>

## TROY SCHOOL DISTRICT

Secretary Coverage

2008-09

Pak B Includes:	Detail
Dental Insurance	<p><b>Administered by:</b> Delta Dental</p> <p>Class 1 (Cleanings (2), Oral Exam)-80%</p> <p>Class 2 (Crowns, Endo/Periodontics)-80%</p> <p>Class 3 (Dentures/Bridges)-80%</p> <p>Class 4 (Orthodontics)-To Age 19-\$800 Life Max</p> <p>Coordination of Benefits – 50%</p>
Vision Insurance	<p><b>Administered by:</b> Vision Service Plan</p> <p><b>Plan:</b> VSP 3</p> <p><b>Vision Exam:</b> Covered in Full if Panel Provider \$35 limit if Non Panel Provider</p> <p><b>Frames:</b> Covered up to \$65.00 retail Panel Covered up to \$55.00 retail Non-Panel</p> <p><b>Lenses (Pair):</b> <i>Single Vision</i> Covered in full if Panel \$38.00 Limit Non-Panel <i>Bifocal</i> Covered in full if Panel \$60.00 Limit if Non-Panel <i>Trifocal</i> Covered in full if Panel \$72.00 Limit if Non-Panel <i>Lenticular</i> Covered in full if Panel \$108.00 Limit if Non-Panel</p> <p><b>Contact Lenses (pair, including exam):</b> Covered in Full Limit \$115.00 If Medically Necessary Limit \$200.00</p>
Life Insurance	<p><b>Administered by:</b> Connecticut General Life Insurance Co.</p> <p><b>Policyholder:</b> MESSA</p> <p><b>Policy Amount:</b> \$31,000.00 Negotiated Life/AD&amp;D</p>
Long Term Disability	<p>Payable at 66 and 2/3 of your salary with a maximum monthly benefit of \$2400.00-60 Calendar Day modified fill elimination period.</p>