



## Medical Comparison: Teacher Plans, 2011-2012

	Priority Health HMO	Blue Care Network HMO	MESSA Super Care 1	MESSA Choices II PPO	
Provider Network	Hospitals: St. Joseph (Ann Arbor, Saline, Howell), Chelsea Physicians: Priority Health Network	Hospitals: St. Joseph (Ann Arbor, Saline, Howell), U of M, Chelsea Physicians: BCN Network	Not Applicable: Traditional Plan	In-Network	Out-of-Network
Plan Type	HMO: Primary Care Physician required, no referral required, in-network coverage only.	HMO: Primary Care Physician required, referrals required, in-network coverage only.	Traditional: Primary Care Physician not required, referrals not required, no network.	PPO: Primary Care Physician not required, referrals not required, in-network and out-of-network coverage.	
Deductible	N/A	N/A	\$100 per person/\$200 per family	\$0	\$250 per person/\$500 per family
Coinsurance			90-10%	100%	80-20%
Out-of-Pocket Maximum			\$1,000	\$0	\$2,000 per person/\$4,000 per family
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	
Hospital Inpatient					
Number of Days	100% - no limit on number of days.	100% - no limit on number of days.	100% - no limit on number of days.	100% - no limit on number of days.	80% of approved amount covered - no limit on number of days.
Special Care Units	100%	100%	100%	100%	80% of approved amount covered
Surgery/Anesthesia/Physician Services	100%	100%	100%	100%	80% of approved amount covered
Ancillary Care (Drugs, Laboratory and X-ray)	100%	100%	100%	100%	80% of approved amount covered
Physical Therapy	100%	100%	90% after deductible	100%	80% of approved amount covered
Maternity Care	100%	100%	100%	100%	80% of approved amount covered
Certified Nurse Midwives	Covered (CNM must be a participating provider with admitting privileges at a participating facility)	Covered (Only when working under the supervision of a Medical Doctor and the billing is through the Medical Doctor)	100%	100%	80% of approved amount covered
Outpatient Services					
Surgical Procedures	100%	100%	100%	100%	80% of approved amount covered
Laboratory & Pathology	100%	100%	100%	100%	80% of approved amount covered
Radiology - Diagnostic/Therapeutic	100%	100%	100%	100%	80% of approved amount covered
Chiropractic Care	\$5 Copay, referral required, spinal manipulation only, limited to 50 visits combined with physical and occupational therapy.	\$5 Copay, Referral Required	90% after deductible	100% - 38 visits per year	80% of approved amount covered - 38 visits per year
Podiatry	100% when medically necessary	Office visit copay may apply when medically necessary	90% after deductible	Office Visit: \$5 copay	80% of approved amount covered
Therapy-Physical/Speech	\$5 Copay, 50 visits for physical/occupational/chiropractic therapy combined; 50 visits for speech therapy; 50 visits for cardio/pulmonary rehabilitation.	Covered in full; limited to 60 consecutive days per medical episode for a combination of therapies	90% after deductible	100% - 60 visits per year.	80% of approved amount covered in physicians office.



Ann Arbor  
Public Schools

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<b>Emergency Services</b>					
Participating Physician Office	\$5 Copay	\$5 Copay	90% after deductible	\$5 Copay	80% of approved amount covered
Hospital Emergency Room	\$25 Copay (Waived if admitted)	\$25 Copay (Waived if admitted)	Hospital & Physician charges covered 100% for accidental injuries; physician charges covered at 90% for emergency illness. 100% for Lab & X-rays.	\$25 Copay (Waived if admitted or results from accidental injury)	\$25 Copay (Waived if admitted or results from accidental injury)
Urgent Care Facility	\$5 Copay (per visit)	\$10 Copay	Hospital & Physician charges covered 100% for accidental injuries; physician charges covered at 90% for emergency illness. 100% for Lab & X-rays.	\$10 Copay (Waived if emergency or accidental injury)	80% of approved amount covered
Notification Requirement	48 Hours after hospital admission.	24 Hours after hospital admission.	72 Hours after hospital admission.	N/A	N/A
Ambulance Services	100% if medically necessary	100% if medically necessary	90% after deductible	100%	100%
<b>Mental Health, Chemical Dependency &amp; Substance Abuse</b>	Contact Priority's Behavioral Health Department if you have questions about your Mental Health or Substance Abuse benefits or coverage at 616-464-8500 or 800-673-8043.	Note: All Mental Health & Substance Abuse services must be approved in advance by our Behavioral Health Dept.800-482-5982. Treatment may be covered as deemed clinically necessary.			
Inpatient Mental Health Care	100% Non Emergency Hospital admissions must be approved in advance by Priority Health.	100%	100% - Requires pre-admission review	100% - Requires pre-admission review	80% of approved amount covered
Outpatient Mental Health Care	\$5 Copay per visit.	\$5 Copay per visit.	90% of approved amount, after deductible	100% covered after \$5 copay	80% of approved amount covered
Inpatient Chemical Dependency/Substance Abuse	100%	100%	100% - Requires pre-admission review	100% - Requires pre-admission review	80% of approved amount covered
Outpatient Chemical Dependency/Substance Abuse	\$5 Copay per visit.	\$5 Copay per visit.	90% of approved amount, after deductible	100% covered after \$5 copay	80% of approved amount covered

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Physician Services	Priority Health HMO	Blue Care Network HMO	MESSA Super Care 1	MESSA Choices II PPO In-Network	MESSA Choices II PPO Out-of-Network
Routine Office Visit	\$5 Copay (Maximum Copayment of \$60 per pregnancy)	\$5 Copay (waived for maternity visits after initial visit)	90% after deductible	\$5 Copay	80% of approved amount covered
Consulting Specialists	\$5 Copay	\$5 Copay (Referral Required)	90% after deductible	\$5 Copay	80% of approved amount covered
Health Maintenance Exams	100% (no copay required for preventive services listed on the Preventive HealthCare Guidelines)	100%	Not Covered	100%	Not Covered
Annual Gynecological (GYN) Exams	100% (no copay required for preventive services listed on the Preventive HealthCare Guidelines)	100%	100% of approved amount, one per calendar year	100%	Not Covered
Pap Smears	100% (no copay required for preventive services listed on the Preventive HealthCare Guidelines)	100%	100%	100%	Not Covered
Well Child Exams	100% (no copay required for preventive services listed on the Preventive HealthCare Guidelines)	100%	Not Covered	100%	Not Covered
Immunizations	100% (no copay required for preventive services listed on the Preventive HealthCare Guidelines)	100%	Preventive flu immunizations for heart, lung & diabetic patients	100%	Not Covered
Allergy Testing/Treatment	\$5 Copay. Injections covered 100%.	100% - Office Visit Copay may apply	90% after deductible	100%	80% of approved amount covered
Laboratory & X-rays	100%	100% - Office Visit Copay may apply	100%	100%	80% of approved amount covered
Infertility Services	50% coverage. Prescription drugs for infertility treatment covered with prescription drug rider.	50% Copay for Infertility Assessment, Testing & Treatment including Prescription Drugs	90% after deductible. In vitro Fertilization is not covered.	Diagnostic Services - \$5 Office Visit Copay  Treatment Services - Not Covered	Not Covered

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<b>Other Services</b>					
Prescription Drugs	\$15 Copay for generic drugs. \$30 Copay for brand drugs.	\$15 Copay for generic drugs. \$30 Copay for brand drugs.	\$10 Copay for generic drugs. \$20 Copay for brand drugs.	\$10 Copay for generic drugs. \$20 Copay for brand drugs.	75% after deductible, minus Copay
Birth Control Pills	\$15 Copay for generic drugs. \$30 Copay for brand drugs.	\$15 Copay for generic drugs. \$30 Copay for brand drugs.	\$10 Copay for generic drugs. \$20 Copay for brand drugs.	\$10 Copay for generic drugs. \$20 Copay for brand drugs.	75% after deductible, minus Copay
Mail Order Drugs	Two Copays for 90 day supply.	Two Copays for 90 day supply.	Two Copays for 90 day supply.	Two Copays for 90 day supply.	
Private Duty Nursing	Not Covered	Not Covered	90%	90% after deductible	90% after deductible
Skilled Nursing Care	Covered up to 730 days combined with subacute, inpatient rehabilitation and Hospice Facility services.	Covered 100% - Limited to 45 days per calendar year	90% after deductible - Custodial Care excluded.	100% - 120 days per calendar year	100% - 120 days per calendar year
Home Health Care	100%	100%	100%	100%	100%
Hospice Care	100%	100%	100%	100%	100%
Durable Medical Equipment	100%	100%	90% after deductible	100%	100%
Prosthetic & Orthotic Services	100% - when approved by Plan	100%	90% after deductible	100%	100%
Voluntary Abortion & Sterilization	50% Copay for abortion, one per 24 months; Sterilization covered 100%	100%	100%	100%	80% of approved amount covered
Dependent Children Continuation	Covered to the end of the year dependent turns 26.	Covered to the end of the year dependent turns 26.	Through year of 26th birthday if provided majority support. Past 26 if full-time student.	Through year of 26th birthday if provided majority support. Past 26 if full-time student.	Through year of 26th birthday if provided majority support. Past 26 if full-time student.
Hearing Care	\$5 Copay for exams/testing. Hearing aids not covered.	\$5 Copay for exams/testing. Aids covered in full, once every 36 months.	Not Covered	Covered - once every three years.	Covered - once every three years.
	<b>800.446.5674 (PriorityHealth.com)</b>	<b>800.662.6667 (MiBCN.com)</b>	<b>888/888.4167 or 800.292.4910 (messa.org)</b>		