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Berkley School District Summary of WMHIP Plans
Benefit Plan (In Network Levels Only) Comparison

	The Pool PPO Benefits Overview (Please see benefit summaries for out-of-network coverage)				
Effective Date	**1/1/2025-12/31/2025**				
PLAN	**BCBSM PPO 1000**	**BCBSM PPO 2000**	**FLEXIBLE BLUE 1650**	**FLEXIBLE BLUE 2000**	**BCBSM PPO 500**
MESSA "Equivalent Plan"	**MESSA CHOICES $1,000/$2,000 0%**	**MESSA CHOICES $2,000/$4,000 10%**	**MESSA ABC PLAN 1 $1,600/$3,200 HSA**	**MESSA ABC PLAN 2 $2,000/$4,000 HSA 0%**	**Essentials by MESSA $375/$750 20%**
Deductible	$1,000 per member, $2,000 per family	$2,000 per member, $4,000 per family	$1,650 per member, $3,300 per family	$2,000 per member, $4,000 per family	$500 per member, $1,000 per family
Coinsurance Member Share	0% of approved amount, 100% covered for most services	20% of approved amount up to a maximum of $2,500/$5,000	0% of approved amount, 100% covered for most services	0% of approved amount, 100% covered for most services	20% of approved amount up to a maximum of $2,500/$5,000
Annual Out of Pocket Maximums	$3,000 per member, $6,000 per family (includes deductible, coinsurance and copays)	$4,500 per member, $9,000 per family (includes deductible, coinsurance and copays)	$2,650 per member, $5,300 per family (includes deductible, coinsurance and copays)	$3,000 per member, $6,000 per family (includes deductible, coinsurance and copays)	$4,500 per member, $9,000 per family (includes deductible, coinsurance and copays)
Medical Coverage Details					
Preventive Care	100% covered	100% covered	100% covered	100% covered	100% covered
Office Visits (In person)	$20 copay	$30 PCP / $50 Specialist	100% after deductible	100% after deductible	$30 PCP / $50 Specialist
Virtual Care	$20 copay	$30 copay	100% after deductible	100% after deductible	$30 copay
Chiropractic Care / Manipulative Therapy	Covered 100%, limited to 24 visits per calendar year	$30 copay, limited to 12 visits per calendar year	100% after deductible, limited to 24 visits per calendar year	100% after deductible, limited to 24 visits per calendar year	$30 copay, limited to 12 visits per calendar year
Facility Urgent Care Visits	100% after deductible	Covered - 100% after $60 copay	100% after deductible	100% after deductible	Covered - 100% after $60 copay
Hospital Emergency Room	Covered - 100% after $50 copay; copay waived if admitted or for an accidental injury	Covered - 100% after $150 copay; copay waived if admitted or for an accidental injury	100% after deductible	100% after deductible	Covered - 100% after $150 copay; copay waived if admitted or for an accidental injury
MESSA Renewal Benefit Plans					
Other Covered Services					
Bariatric Surgery	100% after deductible	50% after deductible	100% after deductible	100% after deductible	50% after deductible
Hearing Aids	100% covered	100% covered	100% covered	100% covered	100% covered
Physical, Speech & Occupational therapy	up to a combined 60 visits per cal year; covered 100% after deductible	up to a combined 60 visits per cal year; covered 80% after deductible	up to a combined 60 visits per cal year; covered 100% after deductible	up to a combined 60 visits per cal year; covered 100% after deductible	up to a combined 60 visits per cal year; covered 80% after deductible
Massage Therapy	100% after deductible (up to 24 visits per cal year)	Not Covered	Not Covered	Not Covered	Not Covered
Prescription Drugs					
Select Over the Counter Drugs/Generic Medications	$10 copay	$20 copay	$10 copay after deductible	$10 copay after deductible	$20 copay
Preferred Brand Name Medications	$40 copay	$40 copay	$40 copay after deductible	$40 copay after deductible	$40 copay
Non-Preferred Brand Name Medications	$40 copay	$80 copay	$40 copay after deductible	$40 copay after deductible	$80 copay
Preferred Specialty Medication	N/A - included with above tier	15% of approved amount up to $200	N/A - included with above tier	N/A - included with above tier	N/A - included with above tier
Non-Preferred Specialty Medication	N/A - included with above tier	25% of approved amount up to $300	N/A - included with above tier	N/A - included with above tier	N/A - included with above tier
Mail Order Programs for 31-90 day Supply	2x the 30-day cost share	2x the 30-day cost share (Specialty is limited to 30 days)	2x the 30-day cost share	2x the 30-day cost share	2x the 30-day cost share