

SHERIFF DEPUTIES MEDICAL OPTIONS COMPARISON

Important Note: The information contained on this comparison is intended to be an easy to read summary to help you and your family make choices among the different options available to you. Be sure to carefully study each option before making your choice. This comparison summarizes some of the provisions and certain features of each plan. It cannot modify or affect the coverage or benefits provided in any way. No right will accrue to you and/or your eligible dependents because of any statement, error or omission from this comparison. Its provisions do not constitute amendments, modifications or changes in any existing contract.

BENEFITS	<u>ONLY AVAILABLE TO DEPUTIES CURRENTLY ENROLLED</u> Blue Cross/Blue Shield Traditional Plan (BC/BS) Hospital and Medical/Surgical with Master Medical (MM)	<u>AVAILABLE TO ALL DEPUTIES</u> Blue Cross/Blue Shield Comprehensive Major Medical (CMM) Comprehensive Major Medical Plan	<u>AVAILABLE TO ALL DEPUTIES</u> Blue Preferred Plan (PPO) Hospital & Medical/Surgical with Master Medical (MM)	<u>NOT AVAILABLE TO DEPUTIES HIRED AFTER 12/02/09</u> Health Alliance Plan (HAP) HMO
INPATIENT HOSPITAL CARE				
General Conditions ◆ Semi-Private Room ◆ Drugs ◆ Intensive Care Unit ◆ Meals ◆ Hospital Equipment ◆ Special Diets ◆ Nursing Care	120 days, 60-day renewal ; additional days under MM with no deductible, co-pays	80% after deductible	120 days, 60-day renewal; additional days under MM with no deductible, co-pay	Covered
OUTPATIENT HOSPITAL CARE				
Emergency Room ◆ Accidental Injuries ◆ Medical Emergencies	Covered Covered for approved diagnosis	80% after deductible 80% after deductible	Covered Covered	Covered; \$25 Co-pay Covered; \$25 Co-pay
Physical Therapy	60 consecutive days per condition; additional days under MM; 90% after deductible	80% after deductible	60 consecutive days per condition; additional days under MM, 90% after the deductible	Covered-60 combined annual visits for PT/OT/ST
MENTAL HEALTH CARE				
Inpatient Mental Health Care	120 days (combined with inpatient care days), 60 day renewal; additional days under MM; no deductible, co-pays	80% after deductible	120 days (combined with inpatient care days), 60 day renewal; additional days under MM; no deductible, co-pays	Covered
Inpatient Substance Abuse Care Chemical Dependency	120 days (combined with inpatient care days), 60 day renewal; (no MM benefits)	80% after deductible	120 days, (combined with inpatient care days), 60 day renewal (no MM benefits)	Covered
Outpatient Mental Health Care	90% under MM after deductible	80% after deductible	90% under MM after deductible	\$20 Co-pay
Outpatient Substance Abuse Care Chemical Dependency	Covered 100% of approved amount, no Master Medical	80% after deductible	Covered 100% of approved amount, no Master Medical	\$20 Co-pay
SPECIAL HOSPITAL PROGRAMS				
Hospice Care	Covered up to a lifetime maximum that is adjusted annually	80% up to a maximum that is adjusted annually	Covered up to a lifetime maximum that is adjusted annually	Covered up to 210 days per lifetime.
Specified Human Organ Transplants	Covered up to program maximums in approved facilities	80% after deductible, in approved facilities	Covered up to program maximums in approved facilities	Covered if authorized

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	Blue Cross/Blue Shield Traditional Plan (BC/BS) Hospital and Medical/Surgical with Master Medical (MM)	Blue Cross/Blue Shield Comprehensive Major Medical (CMM) Comprehensive Major Medical Plan	Blue Preferred Plan (PPO) Hospital & Medical/Surgical with Master Medical (MM)	Health Alliance Plan (HAP) HMO
MEDICAL AND SURGICAL CARE				
Surgery	Voluntary second surgical opinion on certain surgeries	80% after deductible; voluntary second surgical opinion on certain surgeries.	Voluntary second surgical opinion; \$20 Co-pay	Voluntary second surgical opinion; \$20 Co-pay
◆ Technical Surgical Assist.	Covered	80% after deductible	Covered	Covered
◆ Anesthesia	Covered	80% after deductible	Covered	Covered
Maternity Care	Covered	80% after deductible	Covered	Covered
◆ Delivery	90% under MM after deductible	80% after deductible	100% under basic; no co-pay	\$20 Co-pay per visit
◆ Pre- and Post-Natal Care				
Inpatient Medical Care	General-unlimited Mental health care-45 days	80% after deductible Mental health care — 45 days	General — unlimited Mental health care — 45 days	Covered
Inpatient Consultations	Covered	80% after deductible	Covered	Covered
Emergency Care* (Physician)	90% under MM after deductible	80% after deductible	100% under MM after deductible	\$25 co-pay
◆ Accidental Injuries	90% under MM after deductible	80% after deductible	100% under MM after deductible	\$25 co-pay
◆ Medical Emergencies				
* Life threatening emergencies				
Laboratory & Pathology	Covered-\$5 or 10 %co-pay	80% after deductible	Covered	Covered
Diagnostic Services	Covered-\$5 or 10 %co-pay	80% after deductible	Covered	Covered
Diagnostic and Therapeutic Radiology	Covered-\$5 or 10% co-pay	80% after deductible	Covered	Covered
ADDITIONAL BENEFITS				
Office Visits	90% under MM after deductible	80% after deductible	\$20 Co-pay	\$20 Co-pay***
Well-Baby Care	Not covered	Not Covered	\$20 Co-pay (up through 1 year)	\$20 Co-pay***
Chiropractic Services	20 Visits first 90 consecutive days, after 90 days limited to 2 visits per month.	Covered 38 visits per calendar yr	20 Visits first 90 consecutive days, after 90 days limited to 2 visits per month. \$20 Co-pay.	Not Covered
Immunizations	Not covered	Not Covered	\$20 Co-pay (up through age 6)	Covered
Allergy Testing	90% under MM after deductible	80% after deductible	Covered	\$20 Co-pay***
Allergy Therapy	90% under MM after deductible	80% after deductible	Covered	Covered
Ambulance Services	90% under MM after deductible	80% after deductible	90% under MM after deductible	Covered
Prosthetic Appliances	90% under MM after deductible	80% after deductible	90% under MM after deductible	Covered
Durable Medical Equipment	90% under MM after deductible	80% after deductible	90% under MM after deductible	Covered
Private Duty Nursing	75% under MM after deductible	80% after deductible	75% under MM after deductible	Not Covered
Skilled Nursing Facility	Covered	80% after deductible	Covered	Covered
Assisted Reproductive Technologies	Not Covered	Not Covered	Not Covered	1 attempt of artificial insemination per lifetime
Voluntary Sterilization	Not covered	80% after deductible	Covered	Covered
Routine Pap Smear	Covered	80% after deductible	Covered*	Covered
Routine Mammogram	Covered	80% after deductible	Covered	Covered
Routine Physical	Not covered	Not Covered	\$20 co-pay; labs not covered*	\$20 Co-pay

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			*If a routine PAP smear and physical are performed separately, only one is covered in a 12 month period-not both.	***All services performed during one visit will be a one time \$20 Co-pay.
PROGRAM PROVISIONS				
Deductibles, Co-payments and Dollar Limitations	<u>Basic:</u> No deductible, co-pays as noted: <u>Master Medical:</u> Deductible; \$200 per person, \$400 per family per calendar year. <u>MM Co-payments:</u> 10% for general services (\$1,000 out-of-pocket maximum); 10% for mental health care (separate \$1,000 out of pocket maximum) and 25% for private duty nursing (separate from out of pocket maximums above). <u>Maximum:</u> None on Basic. \$1 million master medical additional benefits. \$1 million per member per covered type of organ transplant.	<u>Deductible:</u> \$350 per person, \$700 per family, per calendar year. Co-pays as noted. <u>Co-payments:</u> 20% general services (\$1,000 per person out of pocket max. \$2,000 per family max.); 20% mental health care and substance abuse treatment (separate \$1,000 per person out of pocket max, \$2,000 per family max); 20% private duty nursing (separate from out of pocket maximums above). <u>Maximum:</u> \$1 million per member per covered type of organ transplant. \$5 million per member lifetime other services.	<u>Basic:</u> No deductible, co-pays as noted: \$1 million maximum per covered type of organ transplant. <u>Master Medical:</u> Deductible; \$200 per person, \$400 per family per calendar year. <u>MM Co-payments:</u> 10% for general services (\$1,000 out-of-pocket maximum); 10% for mental health care (separate \$1,000 out of pocket maximum) and 25% for private duty nursing (separate from out of pocket maximums above). <u>Maximum:</u> \$5 million per member lifetime maximum.	Co-pays as noted
Payment of Covered Services	<u>Participating Hospitals:</u> 100% of covered benefits, less applicable co-pays. <u>Non-participating Hospitals:</u> Inpatient care in acute-care hospital-\$70 a day, less applicable co-pays. Inpatient care in other hospitals-\$15 a day, less applicable co-pays. <u>Medicare Surgical:</u> 100% of BCBSM's approved amount, less applicable co-pays.		<u>Preferred (Network) Hospitals:</u> 100% of covered benefits, less applicable co-pays. <u>Non-Network Hospitals:</u> 85% of BCBSMS approved payment amount, less applicable co-pays (refer to non-participating under Traditional option). <u>Preferred (Network) Physicians:</u> 100% of BCBSM's scheduled payment amount, less applicable co-pays. <u>Non-network Physicians:</u> 85% of BCBSM's scheduled payment amount, less applicable co-pays.	Co-pays as noted.

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PRESCRIPTION DRUG PROGRAM				
NAVITUS (except HAP, which have their own prescription coverage). www.navitus.com WellDyneRx - Mail Order www.WelldyneRX.com <i>Note: While in the hospital, all drugs are covered under your health plan.</i>	<u>NAVITUS Participating /Network Pharmacies:</u> Covered, co-pays, \$5 Most Generics/Some Brands; \$10 Preferred Brands/Some Generics; \$25 Non-Preferred Brands. Birth Control pills not covered. <u>Non-participating/Non-network Pharmacies:</u> Paid at 75% of allowed cost, less \$5, \$10 or \$25 Co-pay. WELLDYNERX Also, available is the mail order program for drugs taken on a long-term basis. A three month supply can be ordered for a one month co-pay. Also, available for maintenance drugs taken on a long-term basis, a three-month supply can be obtained for a one-month co-pay at your local pharmacy.	<u>NAVITUS Participating /Network Pharmacies:</u> Covered, co-pays, \$5 Most Generics/Some Brands; \$10 Preferred Brands/Some Generics; \$25 Non-Preferred Brands. Birth Control pills covered. <u>Non-participating/Non-network Pharmacies:</u> Paid at 75% of allowed cost, less \$5, \$10 or \$25 Co-pay. WELLDYNERX Also, available is the mail order program for drugs taken on a long-term basis. A three month supply can be ordered for a one month co-pay. Also, available for maintenance drugs taken on a long-term basis, a three-month supply can be obtained for a one-month co-pay at your local pharmacy.	<u>NAVITUS Participating /Network Pharmacies:</u> Covered, co-pays, \$5 Most Generics/Some Brands; \$10 Preferred Brands/Some Generics; \$25 Non-Preferred Brands. Birth Control pills covered. <u>Non-participating/Non-network Pharmacies:</u> Paid at 75% of allowed cost, less \$5, \$10 or \$25 Co-pay. WELLDYNERX Also, available is the mail order program for drugs taken on a long-term basis. A three month supply can be ordered for a one month co-pay. Also, available for maintenance drugs taken on a long-term basis, a three-month supply can be obtained for a one-month co-pay at your local pharmacy.	HAP <u>Participating /Network Pharmacies:</u> *Covered, co-pays \$5 Most Generic; \$10 Select Brand name; \$25 Non-Preferred. Birth Control Pills covered. <u>Non-Network Pharmacies:</u> Not Covered. *If a prescription is written DAW (Dispense As Written) by a physician for a brand name drug and a generic is available, your responsible for the full cost differential between the cost of the brand and the co-pay of the generic drug, unless the physician has filed an approved medical exception. Also, available for maintenance drugs taken on a long-term basis. A 35 day supply or 100 doses, whichever is greater, can also be obtained for one co-pay at your local pharmacy.

Note: Hearing aides and services are not covered under any Oakland County medical plans.

+ Corrections Deputies Hired after 12/2/09 not eligible for HAP.