MEDICAL / PRESCRIPTION DRUG BENEFITS COMPARISON

The following chart describes the essential features of the health insurance plan in general terms. Unless otherwise specified, the summary describes in-network services. It is not intended to be a full description of coverage. The complete plan is described in the applicable collective bargaining agreement, executive benefit plan and/or Wayne County Health and Welfare Benefit Plan of 2006. A copy of the benefit plan is available from the plan administrator upon request to all interested parties. A certificate is available from the insurer upon request to all interested parties.

Medical and Prescription Drug Plan Benefits

Benefit Description	Simply Blue* HDHP *(*formerly known as Flexible Blue)*	Blue Care Network HDHP HMO	Blue Care Network PCP Focus HDHP HMO
Plan Type	HDHP / PPO	HDHP / HMO	HDHP / HMO
CLICK HERE for Summary of Benefits & Coverage Detail (http://www.waynecounty.com/phr/benefits-information.htm)			
Employee Monthly Contributions Toward Health Plan Enrollment (for the period 1/1/2017 through 12/31/2017)			
Single person coverage	$114.51	$103.50	$87.16
Two person coverage	$274.83	$249.32	$209.18
Family coverage	$343.54	$311.82	$261.47
Services in the Hospital			
Number of days of care	Unlimited	Unlimited	Unlimited
Semi-private room and intensive care	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Miscellaneous services	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Surgery and all related surgical services	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Anesthesia	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Laboratory tests and x-rays	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Physical therapy	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Medicines and drugs	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Human Organ Transplant	Covered 80% after deductible according to plan guidelines except experimental; in designated facilities only for heart, heart/lung, lung, pancreas, and liver transplant.	Covered 80% after deductible according to plan guidelines except experimental; in designated facilities only for heart, heart/lung, lung, pancreas, and liver transplant.	Covered 80% after deductible according to plan guidelines except experimental; in designated facilities only for heart, heart/lung, lung, pancreas, and liver transplant.
Emergency Care (Medical and Accidental)			
Hospital and physician services	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Urgent care facility	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Ambulance	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Physician Services			
Routine / periodic physical exam	Covered 100% once per calendar year	Covered 100% once per calendar year	Covered 100% once per calendar year
Office visits with medical diagnosis	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Consulting specialist care	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Maternity Services Provided by a Physician			
Outpatient post-natal care	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Delivery in hospital	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible

Benefit Description	Simply Blue* HDHP *(*formerly known as Flexible Blue)*	Blue Care Network HDHP HMO	Blue Care Network PCP Focus HDHP HMO
Newborn baby care in hospital	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Prescription Drugs			
Generic drug - Preferred (30-day supply)	Covered with $10 copay after deductible	Covered with $10 copay after deductible	Covered with $4 copay after deductible
Generic drug - Non-Preferred (30-day supply)	Covered with $10 copay after deductible	Covered with $10 copay after deductible	Covered with $15 copay after deductible
Brand-name drug - Formulary (30-day supply)	Covered with $35 copay after deductible	Covered with $35 copay after deductible	Covered with $40 copay after deductible
Brand-name drug - Non-Formulary (30-day supply)	Covered with $50 copay after deductible	Covered with $50 copay after deductible	Covered with $80 copay after deductible
Specialty drug - Preferred	Covered with $50 copay after deductible	Covered with $50 copay after deductible	20% coinsurance after deductible (max $200)
Specialty drug - Non-Preferred	Covered with $50 copay after deductible	Covered with $50 copay after deductible	20% coinsurance after deductible (max $300)
Mail-order drug / 90-day retail (90-day supply)	2 times 30-day supply copay after deductible	2 times 30-day supply copay after deductible	2 times 30-day supply copay after deductible
Annual copay dollar maximums (out-of-pocket maximums)	Included in overall plan out-of-pocket maximums	Included in overall plan out-of-pocket maximums	Included in overall plan out-of-pocket maximums
Other Features	~ Custom Select Formulary ~ $500 per member per year covered at 100% for preventive drugs (as defined by insurance carrier) ~ Mandatory generic ~ Step Therapy ~ 90-day retail program	~ Mandatory generic ~ Step Therapy ~ 90-day retail program	~ Custom Select Formulary ~ Mandatory generic ~ Step Therapy ~ 90-day retail program
Diagnostic and Therapeutic Procedures			
Laboratory tests	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Radiation therapy	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Physical, speech & occupational Therapy	Covered 80% after deductible up to a combined 60 visits per calendar year	Covered 80% after deductible	Covered 80% after deductible up to one period of treatment for any combination of therapies within 60 consecutive calendar days per calendar year
Diagnostic radiology	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Preventative Services			
Routine / Preventative Physical Exam	Covered 100% once per calendar year	Covered 100% once per calendar year	Covered 100% once per calendar year
Well-baby care visits	Covered 100%: ~ 8 visits, birth through 12 months ~ 6 visits, 13 mos. through 23 mos. ~ 6 visits, 24 mos. through 35 mos. ~ 2 visits, 36 mos. through 47 mos.	Covered 100%	Covered 100%: ~ 8 visits, birth through 12 months ~ 6 visits, 13 mos. through 23 mos. ~ 6 visits, 24 mos. through 35 mos. ~ 2 visits, 36 mos. through 47 mos.
Immunizations	Covered 100%	Covered 100%	Covered 100%

Benefit Description	Simply Blue* HDHP *(*formerly known as Flexible Blue)*	Blue Care Network HDHP HMO	Blue Care Network PCP Focus HDHP HMO
Voluntary Female Sterilization	Covered 100%	Covered 100% (tubal ligation to prevent conception)	Covered 100%
IUDs and other contraceptive devices	Covered 100%	Covered 100%	Covered 100%
Mammography screening	Covered 100% once per calendar year	Covered 100% once per calendar year	Covered 100% once per calendar year
Pap Smear	Covered 100% once per calendar year	Covered 100% once per calendar year	Covered 100% once per calendar year
Fecal Occult Blood Screening	Covered 100% once per calendar year	Covered 100% once per calendar year	Covered 100% once per calendar year
Flexible sigmoidoscopy exam	Covered 100% once per calendar year	Covered 100% once per calendar year	Covered 100% once per calendar year
Prostate specific antigen (PSA) screening	Covered 100% once per calendar year	Covered 100% once per calendar year	Covered 100% once per calendar year
Mental Health Care Services			
Outpatient psychiatric services	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Inpatient psychiatric services	Covered 80% after deductible up to 60 days per calendar year	Covered 80% after deductible	Covered 80% after deductible
Substance Abuse Treatment			
Outpatient substance abuse treatment	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Inpatient substance abuse treatment	Covered 80% after deductible up to 60 days per calendar year	Covered 80% after deductible	Covered 80% after deductible
Alternative to Hospital Care			
Skilled nursing facility	Covered 80% after deductible up to 90 days per calendar year	Covered 80% after deductible (up to 730 days renewable after 60 days)	Covered 80% after deductible up to 45 days per calendar year
Home health care services	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Custodial care facility	Not covered	Not covered	Not covered
Hospice care facility	Covered 80% after deductible up to four 90 day periods; limited to dollar maximum that is reviewed and adjusted periodically	Covered 80% after deductible	Covered 80% after deductible
Chiropractic Services	Covered 80% after deductible up to 24 visits per calendar year	Covered 80% after deductible up to 30 referred visits per calendar year	Covered 80% after deductible up to 30 referred visits per calendar year
Appliances and Prosthetic Devices	Covered 80% after deductible	Covered 80% after deductible	Covered 50% after deductible
Durable Medical Equipment	Covered 80% after deductible	Covered 80% after deductible	Covered 50% after deductible
Vision Services			
Eye examination	Covered with $10 copay for routine eye exam under separate BCBSM Vision rider if also enrolled in Heritage Vision Plan; covered 80% after deductible for all other medically necessary vision services	Covered with $10 copay for routine eye exam under separate BCBSM Vision rider (separate card) if also enrolled in Heritage Vision Plan; covered 80% after deductible for all other medically necessary vision services	Covered with $10 copay for routine eye exam under separate BCBSM Vision rider (separate card) if also enrolled in Heritage Vision Plan; covered 80% after deductible for all other medically necessary vision services
Corrective lenses	Not covered	Not covered	Not covered
Eyeglass frames	Not covered	Not covered	Not covered

Benefit Description	Simply Blue* HDHP *(*formerly known as Flexible Blue)*	Blue Care Network HDHP HMO	Blue Care Network PCP Focus HDHP HMO
Hearing Services			
Hearing screening	Not covered	Not covered	Not covered
Hearing examination	Covered 80% after deductible with medical diagnosis only	Covered 80% after deductible with medical diagnosis only	Covered 80% after deductible with medical diagnosis only
Hearing aids	Not covered	Not covered	Not covered

Benefit Description	Simply Blue* HDHP *(*formerly known as Flexible Blue)*	Blue Care Network HDHP HMO	Blue Care Network PCP Focus HDHP HMO
Deductibles, Copays, Benefit and Out-of-Pocket Maximums			
In-network annual deductible	$1,300 for a single-person contract or $2,600 for a family contract (2 or more mbrs) through calendar year 2017 *~ Full-family deductible MUST be met under a two-person or family contract before any benefits are paid for any person on the contract* *~ Does NOT include 4th quarter carryover*	$1,300 for a single-person contract or $2,600 for a family contract (2 or more mbrs) through calendar year 2017 *~ Full-family deductible MUST be met under a two-person or family contract before any benefits are paid for any person on the contract* *~ Does NOT include 4th quarter carryover*	$1,300 for a single-person contract or $2,600 for a family contract (2 or more mbrs) through calendar year 2017 *~ Full-family deductible MUST be met under a two-person or family contract before any benefits are paid for any person on the contract* *~ Does NOT include 4th quarter carryover*
Out-of-network annual deductible	$2,600 for a single-person contract or $5,200 for a family contract (2 or more mbrs) through calendar year 2017. *~ Full-family deductible MUST be met under a two-person or family contract before any benefits are paid for any person on the contract.* *~ Does NOT include 4th quarter carryover.*	Not applicable	Not applicable
In-network flat-dollar copays	~ $10 routine eye exam copay not subject to deductible covered under separate BCBSM Vision rider if also enrolled in Heritage Vision Plan ~ Prescription drugs covered as described in previous section after deductible has been met	~ $10 routine eye exam copay not subject to deductible covered under separate BCBSM Vision rider (separate card) if also enrolled in Heritage Vision Plan ~ Prescription drugs covered as described in previous section after deductible has been met	~ $10 routine eye exam copay not subject to deductible covered under separate BCBSM Vision rider (separate card) if also enrolled in Heritage Vision Plan ~ Prescription drugs covered as described in previous section after deductible has been met
In-network coinsurance	20% unless otherwise specified	20% unless otherwise specified	20% unless otherwise specified
Out-of-network coinsurance	40% unless otherwise specified	Not applicable	Not applicable
In-network annual coinsurance out-of-pocket maximums (OOPM)	$1,000 for a single-person contract or $2,000 for a family contract (2 or more mbrs) each calendar year. *~ Full-family annual coinsurance dollar maximum MUST be met under a two-person or family contract before coinsurance no longer applies.*	$1,000 for a single-person contract or $2,000 for a family contract (2 or more mbrs) each calendar year. *~ Full-family annual coinsurance dollar maximum MUST be met under a two-person or family contract before coinsurance no longer applies.*	$1,000 for a single-person contract or $2,000 for a family contract (2 or more mbrs) each calendar year. *~ Full-family annual coinsurance dollar maximum MUST be met under a two-person or family contract before coinsurance no longer applies.*
Out-of-network annual coinsurance out-of-pocket maximums (OOPM)	$2,000 for a single-person contract or $4,000 for a family contract (2 or more mbrs) each calendar year. *~ Full-family annual coinsurance dollar maximum MUST be met under a two-person or family contract before coinsurance no longer applies.*	Not applicable	Not applicable
In-network annual true out-of-pocket (TROOP) maximums disclosed consistent with Affordable Care Act (ACA) ***~ Includes all out-of-pocket expenses including all in-network deductibles, coinsurance and copays for all services.***	$2,300 for a single-person contract or $4,600 for a family contract (2 or more mbrs) through calendar year 2017	$2,300 for a single-person contract or $4,600 for a family contract (2 or more mbrs) through calendar year 2017	$2,300 for a single-person contract or $4,600 for a family contract (2 or more mbrs) through calendar year 2017

Benefit Description	Simply Blue* HDHP (*formerly known as Flexible Blue)	Blue Care Network HDHP HMO	Blue Care Network PCP Focus HDHP HMO
Out-of-network annual true out-of-pocket (TROOP) maximums disclosed consistent with Affordable Care Act (ACA) ***~ Includes all out-of-pocket expenses including all out-of-network deductibles, coinsurance and copays for all services.***	$4,600 for a single-person contract or $9,200 for a family contract (2 or more mbrs) through calendar year 2017	Not applicable	Not applicable
Health Savings Account (HSA) Qualified	Yes	Yes	Yes
Insurance Company Contact Information			
Insurance Carrier	**Blue Cross Blue Shield of MI (BCBSM)**	**Blue Care Network (BCN)**	**Blue Care Network (BCN)**
Customer Service Number	(877) 790-2583	(800) 662-6667	(800) 662-6667
Address	600 E. Lafayette Blvd Detroit, MI 48226	20500 Civic Center Dr. Southfield, MI 48076	20500 Civic Center Dr. Southfield, MI 48076
Web Site	www.bcbsm.com	www.bcbsm.com	www.bcbsm.com

BENEFITS COMPARISON

The following comparison chart describes the essential features of the health insurance plans in general terms. ***Unless otherwise specified, the summary describes in-network benefits.*** *It is not intended to be a full description of coverage. The complete plans are described in the certificates of coverage issued by each plan. A certificate is available from the insurer upon request to all interested parties.*

Dental Plan Benefits

Benefit Description	Delta Dental EPO Plan	Delta Dental PPO Standard Plan	Golden Dental Smile Guard Plan	Golden Dental Radiant Plan
Plan Type	EPO	PPO	DHMO	DHMO
Employee Monthly Contributions Toward Health Plan Enrollment (for the period 1/1/2017 through 12/31/2017)				
Single person coverage	$0.00	$15.50	$0.00	$25.57
Two person coverage	$0.00	$49.21	$0.00	$47.35
Family coverage	$0.00	$95.64	$0.00	$74.28
Diagnostic and Preventative Services				
Examinations, x-rays, cleanings and flouride treatment	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Restorative Services				
Fillings, crowns and repairs / relines to existing prosthetic appliances	Not covered	Covered at 100%	Covered at 50% - no maximum	Covered ar 100% - no maximum
Oral Surgery				
Extractions and surgery performed by a dentist	Not covered	Covered at 100%	Covered at 50% - no maximum	Covered at 100% - no maximum
When performed by a specialist	Not covered	Covered at 100%	Covered at 30% - no maximum	Covered at 85% - no maximum
Endodontic Services				
Root canals performed by a dentist	Not covered	Covered at 85%	Covered at 50% - no maximum	Covered at 100% - no maximum
Root canals and treatment of damaged nerves performed by a specialist	Not covered	Covered at 85%	Covered at 30% - no maximum	Covered st 85% - no maximum
Prosthodontic Care				
Construction of dentures and bridges	Not covered	Covered at 85%	Covered at 50% - no maximum	Covered at 85% - no maximum
Periodontic Services				
Gum treatment and appliances	Not covered	Covered at 85%	Covered at 30% - no maximum	Covered at 85% - no maximum
Orthodontic Services				
Correction of malposed teeth	Not covered	Covered at 50% to a lifetime maximum of $1,000 with NO AGE RESTRICTIONS	Plan pays $1,800 up to age 19; $1,500 over age 19 (member, spouse, dependents)	Covered at 100% through age 18; age 19 and over covered with $1,250 co-payment.
Annual Benefit Maximum	No Maximum	$1,000	No Maximum for General; No Maximum for Specialty	No Maximum for General; No Maximum for Specialty
Insurance Company Contact Information				
Insurance Carrier	Delta Dental	Delta Dental	Golden Dental Plans, Inc.	Golden Dental Plans, Inc.
Customer Service Number	(800) 524-0149	(800) 524-0149	(800) 451-5918	(800) 451-5918
Address	PO Box 9089 Farmington Hills, MI 48333	PO Box 9089 Farmington Hills, MI 48333	29377 Hoover Road Warren, MI 48093	29377 Hoover Road Warren, MI 48093
Web Site	www.DeltaDentalMI.com	www.DeltaDentalMI.com	www.goldendentalplans.com	www.goldendentalplans.com

BENEFITS COMPARISON

The following chart describes the essential features of the health insurance plan in general terms. Unless otherwise specified, the summary describes in-network services. It is not intended to be a full description of coverage. The complete plan is described in the applicable collective bargaining agreement, executive benefit plan and/or Wayne County Health and Welfare Benefit Plan of 2006. A copy of the benefit plan is available from the plan administrator upon request to all interested parties. A certificate is available from the insurer upon request to all interested parties.

Vision Plan Benefits

Benefit Description	Vision Insurance Plan
Plan Type	Provider Plan
Employee Monthly Contributions Towards Health Plan Enrollment (for the period 1/1/2016 through 12/31/2016)	
Single person coverage	None
Two person coverage	
Family coverage	
Vision exams	Covered under medical plan with $10 copay at least once every two years
Eyeglasses	
Lenses	One pair of single vision, bifocal, trifocal and lenticular lenses covered at 100% in-network; reimbursed up to specified dollar maximum out-of-network
Frames	Covered in-network up to $75 retail allowance; 20% in-network preferred pricing discount for frame costs exceeding $75 allowance; reimbursed up to $30 out-of-network.
Tint	Covered 100% in-network
Other lens upgrades: progressive lenses, thin lenses, anti-reflective coating, UV protection, scratch coating, etc.	20% in-network preferred pricing discount granted for all lens upgrades not covered by the plan
Contact Lenses	
Elective contacts	Covered in-network up to $100 retail allowance; reimbursed up to $65 out-of-network
Medically necessary	Covered 100% in-network with prior approval for medical necessity; reimbursed up to $200 out-of-network with prior approval
Maximum Benefit	Member eligible for glasses or contact lenses (not both) in any 24-month consecutive period
Policy Period	Minimum 2-year plan enrollment required
Plan Administration Contact Information	
Plan Administrator	**Heritage Vision Plans**
Customer Service	(800) 252-2053
Address	One Woodward Avenue, Suite 2020 Detroit, MI 48226
Web Site	www.heritagevisionplans.com