IMPORTANT NOTE: This document is not a contract. It is intended to provide a comparison of available benefit options and to summarize the provisions and features of each plan. Please refer to the Summary Plan Document (SPD) to confirm coverage details. Every effort has been made to ensure the accuracy of this document. In the event that the information contained in this document differs from the SPD, the information contained within the SPD will prevail. This document does not establish or determine eligibility for benefits or procedures, nor does it constitute an amendment, modification or change to the SPD or to any existing contract. All coverage is subject to medical necessity guidelines as outlined in the SPD.

* In order to be eligible for benefits as specified in the SPD, services received by a Covered Person must be administered or ordered by a Physician, be Medically Necessary for the diagnosis and treatment of an illness or injury and allowable/covered charges, unless otherwise specifically noted in the SPD.

Medical Plan Options Comparison					
Benefits	AVAILABLE TO ALL EMPLOYEES				ONLY AVAILABLE TO EMPLOYEES CURRENTLY ENROLLED
	PPO1 ASR Health Benefits asrhealthbenefits.com	**PPO2** Blue Cross/Blue Shield PPO Community Blue Plan BCBSM.com	**PPO3** ASR Health Benefits asrhealthbenefits.com	**HMO** Health Alliance Plan (HAP) HAP.org	**TRADITIONAL** Blue Cross/Blue Shield Traditional Plan (BC/BS) BCBSM.com
Employee Bi-Weekly Contributions	**$32 / $65 / $75**	**$42 / $70 / $85**	**$16 / $35 / $45**	**$32 / $65 / $75**	**$52 / $89 / $94**
No Coverage Option	Refer to Open Enrollment benefit elections in Workday				
Network(s)	HAP Alliance Health & Life PPO / Physicians Care / Aetna / Multiplan	Blue Cross/Blue Shield	HAP Alliance Health & Life PPO / Physicians Care / Aetna / Multiplan	Health Alliance Plan HMO	Blue Cross/Blue Shield
Deductible(s)	$200 per person/$400 per family per calendar year	$100 per person/$200 per family per calendar year	$250 per person/$500 per family per calendar year	No Deductible	$200 per person/$400 per family per calendar year
Coinsurance	0% for most services; l0% after deductible as noted.	l0% after deductible as noted. 50% for private duty nursing.	20% after deductible as noted. 50% after deductible for private duty nursing.	No Coinsurance	10% after deductible as noted. 25% for private duty nursing.
Coinsurance Maximum	$1,000 per person/family per calendar year.	$500 per person/$1,000 per family per calendar year.	$1,000 per person/$2,000 per family per calendar year.	Not Applicable	$1,000 per person/family per calendar year.
INPATIENT HOSPITAL CARE					
General Conditions Semi-Private Drugs Intensive Care Unit Meals Hospital Equipment Special Diets Nursing Care	100%*	90% after deductible*	80% after deductible*	100%* Bariatric Copay: $1,000	100%*
OUTPATIENT HOSPITAL CARE					
Emergency Room Care Accidental Injuries	$100 copay	$100 copay	$100 copay, deductible and coinsurance may also apply for	$100 copay	$100 copay

Medical Plan Options Comparison					
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Medical Emergencies	Copay waived for accidental injury or if admitted	Copay waived for accidental injury or if admitted	some services. Copay waived for accidental injury or if admitted	Copay waived if admitted	Copay waived for accidental injury or if admitted
Physical Therapy	100%*	90% after deductible* 60 combined visits per calendar year	80% after deductible*	100%* Includes Speech Therapy and Occupational Therapy Up to 60 consecutive visits per benefit period. May be rendered at home.	90% after deductible* 60 combined or consecutive visits per calendar year.
URGENT CARE					
Urgent Care Visits	$20 copay				90% after deductible*
PREVENTATIVE CARE SERVICES					
Routine Health Maintenance Exam – includes chest x-ray, EKG, cholesterol screening andother select lab procedures	100%*				
Routine Physical	100%*				
Routine Gynecological Exam	100%*				
Routine Pap Smear Screening – laboratory and pathology services	100%*				
Well-Baby Child Care Visits • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	100%*	100%* Plan covers 8 visits (birth through 12 months)	100%*	100%* No limits on number of visits	100%* Plan covers 8 visits (birth through 12 months)

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Adult and Childhood Preventive Services and Immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM, ASR and HAP that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100%*				
Routine Fecal Occult Blood Screening	100%*				
Routine Flexible Sigmoidoscopy Exam	100%*				
Routine Prostate Specific Antigen (PSA) Screening	100%*				
Routine Mammogram and Related Reading	100%*	100%* **NOTE:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent coinsurance.	100%* **NOTE:** Medically necessary mammograms are subject to your deductible and percent coinsurance	100%*	100%* **NOTE:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent coinsurance
Colonoscopy – Routine or Medically Necessary	100%*	100%* **NOTE:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent coinsurance.	100%* **NOTE:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent coinsurance	100%*	100%* **NOTE:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent coinsurance.
MENTAL HEALTH CARE					
Inpatient Mental Health	100%*	90% after deductible*	80% after deductible*	100%*	100%*
Outpatient Mental Health Visits	$20 copay	90% after deductible* Office visits $20 copay	$20 copay	$20 copay	100%*
Inpatient Substance Abuse Care Chemical Dependency	100%*	90% after deductible*	$20 copay	100%*	100%*
Outpatient Substance Abuse Care Chemical Dependency	$20 copay	90% after deductible* Office visits $20 copay	$20 copay	$20 copay	100%* In approved facilities only

Medical Plan Options Comparison					
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SPECIAL HOSPITAL PROGRAMS					
Hospice Card	100%*	100%*	80% after deductible*	Covered up to 210 days per lifetime	100% of approved amount
Specified Human Organ Transplants	100%*	90% to 100%* Covered according to plan guidelines.	80% after deductible*	$20 copay	100% in approved facilities
MEDICAL AND SURGICAL CARE					
Surgery	100%*	90% after deductible*	80% after deductible*	100%* Voluntary second surgical opinion; $20 copay.	100%* Voluntary second surgical opinion on certain surgeries.
Technical Surgical Assist.	100%*	90% after deductible*	80% after deductible*	100%*	100%*
Anesthesia	100%*	90% after deductible*	80% after deductible*	100%*	100%*
Maternity Care Delivery	100%*	90% after deductible*	80% after deductible*	100%*	100%*
Pre- and Post-Natal Care	100%*	100%*	100% for some pre-natal visits; otherwise 80% after deductible*	100% pre-natal visits* $20 copay post-natal visits	100% pre-natal visits 90% after deductible post-natal visits*
Inpatient Medical Care	100%*	90% after deductible*	80% after deductible*	100%*	100%*
Inpatient Consultations	100%*	90% after deductible*	80% after deductible*	100%*	100%*
Laboratory & Pathology	100%*	90% after deductible*	80% after deductible*	100%*	90% after deductible*
Diagnostic Services	100%*	90% after deductible*	80% after deductible*	100%*	90% after deductible*
Diagnostic and Therapeutic Radiology	100%*	90% after deductible*	80% after deductible*	Covered*	90% after deductible*
ADDITIONAL BENEFITS					
Office Visits	$20 copay	$20 copay	$20 copay	$20 copay	90% after deductible*
Chiropractic Care	$20 copay Limited to 38 visits per calendar year.	$20 copay Limited to 24 visits per calendar year	$20 copay Limited to 38 visits per calendar year	Not Covered	90% after deductible* Limited to 38 visits per calendar year
Allergy Testing	100%*	100%*	80% after deductible*	$20 copay	90% after deductible*
Allergy Therapy	100%*	100%*	80% after deductible*	100%*	90% after deductible*
Ambulance Services	90% after deductible*	90% after deductible*	80% after deductible*	100%*	90% after deductible*
Durable Medical Equipment	90% after deductible*	90% after deductible*	80% after deductible*	100%*	90% after deductible*

Medical Plan Options Comparison					
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Diabetic Supplies	90% No Annual deductible*	90% after deductible*	80% after deductibe*	100%*	90% after deductible*
Private Duty Nursing	90% after deductible*	50% after deductible*	50% after deductibe*	Not Covered	75% after deductible*
Skilled Nursing	100%*	90% after deductibe*	80% after deductibe*	100%* Voluntary second surgical opinion; $20 copay.	100%* Voluntary second surgical opinion on certain surgeries.
Assisted Reproductive Treatment	Not Covered	Not Covered*	Not Covered	100%* One attempt of artificial insemination per lifetime.	Not Covered
Voluntary Sterilization and FDA Approved Contraceptive Methods	100%*	100%*	100%*	100%*	100%*
PROGRAM PROVISIONS					
Out of Network Services	In general, Plan pays 85% of approved amount less applicable copays. For diabetic supplies, durable medical equipment, and private duty nursing, Plan pays 75% of approved amount after deductible (if applicable).	Plan pays 70% of approved amount, after out-of-network deductible, less applicable copays.	In general, Plan pays 65% of approved amount after deductible less applicable copays. For private duty nursing, Plan pays 50% of approved amount after deductible.	Not covered except for emergencies	
Payment of Covered Services	Preferred (Network) Hospitals: 100% of covered benefits. Non-Network Hospitals: 85% of approved payment amount Preferred (Network) Physicians - Outpatient: 100% after $20 copay. Non-network Physicians - Outpatient: 85% of approved payment amount after $20 copay.	Preferred (Network) Hospitals: 90% of covered benefits, after deductible. Non-Network Hospitals: 70% of approved payment amount after out-of-network deductible. Preferred (Network) Physicians: 100% after $20 copay. Non-network Physicians: 70% of approved payment amount after out-of-network deductible and $20 copay.	Preferred (Network) Hospitals: 80% of covered benefits, less applicable deductible. Non-Network Hospitals: 65% of approved payment amount, after deductible. Preferred (Network) Physicians - Outpatient: 100% after $20 copay. Non-network Physicians - Outpatient: 85% of approved payment amount after $20 copay.	Copays as noted.	Participating Hospitals: 100% of covered benefits Non-participating Hospitals: Inpatient care in acute-care hospital - $70 a day. Inpatient care in other hospitals -$15 a day. Medicare Surgical: 100% of BCBSM's approved amount.

Medical Plan Options Comparison					
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NOTE: Hearing aids and services are not covered under any Oakland County medical plans; however, there is a discount program available through Nations Hearing for a limited time.					
PRESCRIPTION DRUG PROGRAM					
Retail Prescription Carrier	Navitus www.navitus.com	Navitus www.navitus.com	Navitus www.navitus.com	Health Alliance Plan www.HAP.org	Navitus www.navitus.com
Mail Order Prescription Carrier	Birdi www.birdirx.com	Birdi www.birdirx.com	Birdi www.birdirx.com	Pharmacy Advantage PharmacyAdvantageRx.com	Birdi www.birdirx.com
Participating/Network Pharmacies	Covered / Copays: Tier 1: $5 Most Generics/ Some Brands; Tier 2: $20 Preferred Brands/ Some Generics; Tier 3: $40 Non-Preferred products (could include both brand and generic) Select Birth Control pills covered $0 copay.	Covered / Copays: Tier 1: $5 Most Generics/ Some Brands; Tier 2: $20 Preferred Brands/ Some Generics; Tier 3: $40 Non-Preferred products (could include both brand and generic) Select Birth Control pills covered $0 copay.	Covered / Copays: Tier 1: $5 Most Generics/ Some Brands; Tier 2: $20 Preferred Brands/ Some Generics; Tier 3: $40 Non-Preferred products (could include both brand and generic products) Select Birth Control pills covered $0 copay.	Covered / Copays: Tier 1: $5 Most Generic; Tier 2: $20 Select Brand name; Tier 3: $40 Non-Preferred. Select Birth Control pills covered $0 copay.	Covered / Copays: Tier 1: $5 Most Generics/ Some Brands; Tier 2: $20 Preferred Brands/Some Generics; Tier 3: $40 Non-Preferred products (could include brand and generic) Select Birth Control pills covered $0 copay.
Non-Participating/Non-Network Pharmacies	Paid at the in-network cost, less $5, $20 or $40 copay.	Paid at the in-network cost, less $5, $20 or $40 copay.	Paid at the in-network cost, less $5, $20 or $40 copay.	Not Covered	Paid at the in-network cost, less $5, $20 or $40 copay.
Maintenance Drugs	Maintenance drugs taken on a long-term basis can be filled as a three-month supply for a one-month copay through either the Mail Order Drug carrier or at a retail pharmacy.	Maintenance drugs taken on a long-term basis can be filled as a three-month supply for a one-month copay through either the Mail Order Drug carrier or at a retail pharmacy.	Maintenance drugs taken on a long-term basis can be filled as a three-month supply for aone-month copay through either the Mail Order Drug carrier or at a retail pharmacy.	Maintenance drugs taken on a long-term basis – a 30 or 90-day supply, whichever is greater, can be obtained for a one-month copay at your local pharmacy. A 90-day supply of maintenance drugs may be obtained through mail order.	Maintenance drugs taken on a long-term basis can be filled as a three-month supply for a one-month copay through either the Mail Order Drug carrier or at a retail pharmacy.
Note: While in the hospital, drugs are covered under your medical plan	If you request a prescription be filled with a brand name drug and there is a generic equivalent available, you will be responsible for the Tier 3 copay plus the differential between the cost of the brand and the generic drug. If your doctor makes the request, you will be responsible for the Tier 3 copay.	If you request a prescription be filled with a brand name drug and there is a generic equivalent available, you will be responsible for the Tier 3 copay plus the differential between the cost of the brand and the generic drug. If your doctor makes the request, you will be responsible for the Tier 3 copay.	If you request a prescription be filled with a brand name drug and there is a generic equivalent available, you will be responsible for the Tier 3 copay plus the differential between the cost of the brand and the generic drug. If your doctor makes the request, you will be responsible for the Tier 3 copay.	If you request a prescription be filled with a brand name drug and there is a generic available, you will be responsible for the full cost differential between the cost of the brand and the copay of the generic drug. If your doctor makes the request, you will be responsible for the Tier 3 copayment.	If you request a prescription be filled with a brand name drug and there is a generic equivalent available, you will be responsible for the Tier 3 copay plus the differential between the cost of the brand and the generic drug. If your doctor makes the request, you will be responsible for the Tier 3 copay.

Dental Plan Options Comparison				
Benefits	AVAILABLE TO BU 9, 10, & 15 **High Plus** Delta Dental www.deltadentalmi.com	AVAILABLE TO ALL EMPLOYEES **High** Delta Dental www.deltadentalmi.com	AVAILABLE TO ALL EMPLOYEES **Standard** Delta Dental www.deltadentalmi.com	AVAILABLE TO ALL EMPLOYEES **Modified** Delta Dental www.deltadentalmi.com
Employee Bi-Weekly Contributions / (Earning)	$1.15 / $1.73 / $5	$1.15 / $1.73 / $5	$0 / $0 / $0	($1.15) / ($1.73) / ($3.27)
NO COVERAGE Option	Refer to the Open Enrollment benefit elections in Workday.			
Network(s)	Delta Dental PPO / Delta Dental Premier			
DIAGNOSTICS AND PREVENTIVE				
Diagnostics and Preventive Services – routine oral exams, cleanings, fluoride, and space maintainers	100%	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%	100%
Periodontal Maintenance – cleanings following periodontal therapy	100%	100%	100%	100%
Dental Sealants – children 14 years and under	100%	100%	100%	100%
Oral Cancer Brush Biopsy	100%	100%	100%	100%
BASIC SERVICES				
Radiographs – X-rays	85%	85%	85%	50%
Minor Restorative Services– composite (white) fillings and crown repair	85%	85%	85%	50%
Endodontic Services – root canals	85%	85%	85%	50%
Periodontic Services – to treat gum disease	85%	85%	85%	50%
Oral Surgery Services – extractions and dental surgery	85%	85%	85%	50%
Major Restorative Services – crowns	85%	85%	85%	50%

Dental Plan Options Comparison				
BENEFITS	AVAILABLE TO BU 9, 10, & 15 **High Plus** Delta Dental www.deltadentalmi.com	AVAILABLE TO ALL EMPLOYEES **High** Delta Dental www.deltadentalmi.com	AVAILABLE TO ALL EMPLOYEES **Standard** Delta Dental www.deltadentalmi.com	AVAILABLE TO ALL EMPLOYEES **Modified** Delta Dental www.deltadentalmi.com
Other Basic Services – miscellaneous services	85%	85%	85%	50%
Relines and Repairs – to bridges, dentures, and implants	85%	85%	85%	50%
MAJOR SERVICES				
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%	50%
ORTHODONTIC SERVICES				
Orthodontic Services – minor treatment for tooth guidance, full banding treatment, and monthly active treatment visits	50%	50%	50%	50%
Orthodontia Maximum Limit	$1,000 per eligible member per lifetime.			$750 per eligible member per lifetime.
Orthodontic Age Limit	Up to age 19			
PROGRAM/PROVISIONS				
Deductibles	$25 per person / $50 per family/per calendar year			
Maximum Benefit	$1,500 per individual per calendar year. All benefits based on maximum		$1,000 per individual per calendar year. All benefits based on maximum	$750 per individual per calendar year. All benefits based on maximum approved fees.

NOTE: For additional information, refer to the Delta Dental Certificates and Benefit Summaries found OakGov.com/benefits under Medical/Dental/Vision.

Vision Plan Options Comparison		
BENEFITS	AVAILABLE TO ALL EMPLOYEES **High** National Vision Administrators (NVA) www.e-nva.com	AVAILABLE TO ALL EMPLOYEES **Standard** National Vision Administrators (NVA) www.e-nva.com
Employee Bi-Weekly Contributions	$1.35 / $2.88 / $3.85	$0 / $0 / $0
NO COVERAGE Option	No Earning is provided for No Coverage option.	
Network(s)	National Vision Administrators	
EYE EXAM		
Vision Examinations	$5 copayment	
LENSES AND FRAMES		
Lenses and Frames	Lenses: Standard Glass or Plastic / Covered 100% after $7.50 copayment Frames: $100 retail allowance / 20% discount off remaining balance for frames that are not proprietary frame brands.	
CONTACT LENSES		
Contact Lenses	$50 allowance	
PROGRAM/PROVISIONS		
Benefits Payable	Benefit payable every 12 months. Benefit availability will start over on January 1 (following a 12-month period).	Benefit payable every 24 months. Benefit availability will start over on January 1 (following a 24-month period).
Additional Discounts	See the Benefit Summary for additional discounts available.	

NOTE: For additional information refer to the NVA Benefit Summaries found on OakGov.com/benefits under Medical/Dental/Vision.