

Comparison of Medical Benefits

| Benefit | | Traditional | Preferred Provider Organization (PPO) | |
|--|-------------------|---|---|--|
| | | Blue Cross Blue Shield of Michigan | Community Blue In-Network | Community Blue Out-of-Network |
| Inpatient Hospital | | | | |
| Days of Care | | Unlimited | Unlimited | Unlimited |
| Room Type | | Semi-private | Semi-private | Semi-private |
| Hospital Services | | Pays 90% of approved amount after deductible.* | Covered in full | Pays 80% of the approved amount after deductible.* |
| Medical Care | | | | |
| Office Visits | Lower Copay Plan | Plan pays 90% of approved amount after deductible. | \$10 copay | Pays 80% of the approved amount after deductible for medically necessary office visits. |
| | Higher Copay Plan | | \$15 copay | |
| Routine Physical Examinations | | Not Covered | Covered in full. Copay for each office visit may apply. | Not Covered |
| Routine Pediatric Examinations | | Not Covered | Covered in full. Copay for each office visit may apply. | Not Covered |
| Eye and Hearing Examinations | | Not Covered (Eye exam covered for disease or injury of eye and following cataract surgery). Pays 90% of approved amount after deductible. | Not Covered (Eye exam covered for disease or injury of eye and following cataract surgery). Hearing exam covered. | Not Covered (Eye exam covered for disease or injury of eye and following cataract surgery). Hearing exam covered. |
| Laboratory and Pathological Services | | Pays 90% of approved amount after deductible excluding screening procedures such as pap smears and prostate screenings, etc. | Covered in full | Pays 80% of the approved amount after deductible. |
| Radiological Services (x-rays) | | Pays 90% of approved amount after deductible excluding miniature x-rays and screening procedures such as mammograms, etc. | Covered in full | Pays 80% of the approved amount after deductible. |
| Allergy Testing and Injections | | Pays 90% of approved amount after deductible. | Covered in full | Pays 80% of the approved amount after deductible. |
| Outpatient Physical, Speech and Occupational Therapy | | Pays 90% of approved amount after deductible.* | Covered in full; 60 visit maximum per calendar year (including out of network). | Office - pays 80% of the approved amount after deductible.* |
| Durable Medical Equipment as prescribed | | Pays 90% of approved amount after deductible. | Covered in full | Covered in full |
| Childhood Immunizations | | Not Covered | Covered in full | Not Covered |
| Prescription Drugs | Lower Copay Plan | \$5 generic drugs \$5 brand drugs | \$5 generic drugs \$10 brand drugs | Reimbursed at 75% of amount paid minus plan copay. |
| | Higher Copay Plan | \$5 generic drugs \$5 brand drugs | \$5 generic drugs \$15 brand drugs | Reimbursed at 75% of amount paid minus plan copay. |
| | Both Plans | Limited to one month supply Mail-order prescriptions are available. | Limited to one month supply. Includes prescribed birth control medications. Mail-order prescriptions are available. | Limited to one month supply. Includes prescribed birth control medications. |
| Chiropractic Services/Spinal Manipulations | | Pays 90% of approved amount after deductible. Limited to 38 visits per calendar year. | Covered in full. 24 visits per calendar year. | Pays 80% of approved amount after deductible. 24 visits per calendar year. |
| Reproductive Care | | | | |
| Pre and Post Natal Care | | Pays 90% of approved amount after deductible. | Covered in full. Includes care by a certified midwife. | Pays 80% of the approved amount after deductible. Includes care by a certified midwife. |
| Delivery | | Pays 90% of approved amount after deductible.* | Covered in full. Includes care by a certified midwife. | Pays 80% of the approved amount after deductible. Includes care by a certified midwife.* |
| Routine Nursery Care (while mother is in hospital) | | Pays 90% of approved amount after deductible. | Covered in full | Pays 80% of the approved amount after deductible. |
| Infertility Services | | Not Covered | Not Covered | Not Covered |
| Voluntary Abortions | | Pays 90% of approved amount after deductible. | Covered in full | Pays 80% of the approved amount after deductible. |
| Voluntary Sterilization | | Pays 90% of approved amount after deductible. | Covered in full | Pays 80% of the approved amount after deductible. |

| Preferred Provider Organization (PPO) | | Health Maintenance Organizations (HMO) | | |
|--|---|--|--|--|
| DMC Care In-Network | DMC Care Out-of-Network | Health Alliance Plan | Blue Care Network | Total Health Care |
| Unlimited | Unlimited | Unlimited | Unlimited | Unlimited |
| Semi-private | Semi-private | Semi-private | Semi-private | Semi-private |
| Covered in full | Pays 70% of the DMC Care Fee Schedule after deductible. | Covered in full | Covered in full | Covered in full |
| \$10 copay | Pays 70% of the DMC Care Fee schedule after deductible. | \$10 copay | \$10 copay | \$10 copay |
| \$15 copay | | \$15 copay | \$15 copay | \$15 copay |
| Copay applies with each office visit. | Pays 70% of the DMC Care Fee Schedule after deductible. | Copay applies with each office visit. | Copay applies with each office visit. | Copay applies with each office visit. |
| Copay applies with each office visit. | Pays 70% of the DMC Care Fee Schedule after deductible. | Copay applies with each office visit. | Copay applies with each office visit. | Copay applies with each office visit. |
| Copay applies with each office visit. | Pays 70% of the DMC Care Fee Schedule after deductible. | Copay applies with each office visit. | Note: Vision and hearing screenings to determine the need for an examination. An examination is not covered. | Note: Vision and hearing screenings to determine the need for an examination. An examination is not covered. |
| Covered in full | Pays 70% of the DMC Care Fee Schedule after deductible. | Covered in full Copay applies with each office visit. | Covered in full | Covered in full |
| Covered in full | Pays 70% of the DMC Care Fee Schedule after deductible. | Covered in full Copay applies with each office visit. | Covered in full | Covered in full |
| Covered in full | Pays 70% of the DMC Care Fee Schedule after deductible. | Copay applies with each office visit. | Copay applies with each office visit. | Copay applies with each office visit. |
| Covers 60 visits per condition | Pays 70% of the DMC Care Fee Schedule after deductible. | Covered. 60 visits per condition lifetime. | Copay applies with each office visit. | Copay applies with each office visit. 60 visits per lifetime. |
| Covered in full | Pays 70% of the DMC Care Fee Schedule after deductible. | Covered in full for authorized equipment. | Covered in full | Covered in full for authorized equipment. |
| Covered in full | Pays 70% of the DMC Care Fee Schedule after deductible. | Copay applies with each office visit. | Copay applies with each office visit. | Copay applies with each office visit. |
| \$5 generic drugs \$10 brand drugs | Reimbursed at 75% of amount paid minus plan copay. | \$5 generic drugs \$10 brand drugs | \$5 generic drugs \$10 brand drugs | \$5 generic drugs \$10 brand drugs |
| \$5 generic drugs \$15 brand drugs | Reimbursed at 75% of amount paid minus plan copay. | \$5 generic drugs \$15 brand drugs | \$5 generic drugs \$15 brand drugs | \$5 generic drugs \$15 brand drugs |
| Limited to one month supply Includes oral contraceptives Mail-order prescriptions are available. | Limited to one month supply Includes oral contraceptives. | Limited to one month supply Includes prescribed birth control medications. Mail-order prescriptions are available. | Limited to one month supply Includes prescribed birth control medications. Mail-order prescriptions are available. | Limited to one month supply Includes prescribed birth control medications. Mail-order prescriptions are available. |
| Copay for each office visit. \$1,000 maximum per year | Pays 70% of the DMC Care Fee Schedule after deductible. \$1,000 maximum per year | Not Covered. | Covered with limitations. Number of visits determined by physician referral. Spinal manipulation only. Copay for each office visit. | Copay for each office visit. Limited to 20 visits per calendar year. |
| Covered in full | Pays 70% of the DMC Care Fee Schedule after deductible. | Copay applies with each office visit. | Copay applies with each office visit. | Covered in full |
| Covered in full | Pays 70% of the DMC Care Fee Schedule after deductible. | Covered in full | Covered in full | Covered in full |
| Covered in full | Pays 70% of the DMC Care Fee Schedule after deductible. | Covered in full | Covered in full | Covered in full |
| Covered with limitations (Artificial insemination only) | Not Covered | Covered with limitations; Contact plan for details. | Covered with limitations | Covered with limitations |
| Covered in full | Pays 70% of the DMC Care Fee Schedule after deductible. | Not Covered | Covered in full | Covered in full |
| Covered in full | Pays 70% of the DMC Care Fee Schedule after deductible. | Covered with limitations | Covered with limitations | Covered with limitations |