Comparison of Medical Benefits Disclaimer:

The Comparison of Medical Benefits on the following pages contains a general outline of covered benefits and does not include all the benefits, limitations and exclusions of the benefit programs. If there are any discrepancies between the illustrations contained therein and the benefit proposals or official benefit plan documents, the benefit proposals or official benefit plan documents prevail. See the official benefit plan documents for a full list of exclusions. In addition, please be aware that the information contained in these materials is based on our current understanding of the federal health care reform legislation, signed into law in March 2010. Our interpretation of this complex legislation continues to evolve as additional regulatory guidance is provided by the U.S. government. Therefore, we defer to the actual carrier contracts, processes and the law itself as the governing documents. Additional information about your Wayne State University benefits is available at **hr.wayne.edu/tcw/benefits.**

Benefit Plan Comparison - Plan 1	Health Alliance Plan In-Network Only	Blue Care Network In-Network Only	Priority Health		Traditional BCBSM	BCBSM PPO (formerly Community Blue)	
			Tier 1 In-Network Only	Tier 2 In-Network Only		In-Network	Out-of-Network
Inpatient Hospital							
Hospital Services	Covered in full	Covered in full	Covered in full	20% coinsurance after deductible	Plan pays 90% after deductible (non-emergency services must be rendered in a **participating** hospital)	Covered in full (non-emergency services must be rendered in a **participating** hospital)	80% after out-of-network deductible (non-emergency services must be rendered in a **participating** hospital)
Medical Care							
Office Visits: In Person	$20 copay	$20 copay	$20 copay	$40 copay	$20 copay	$20 copay	80% after out-of-network deductible
Telemedicine/Virtual Visits	$20 copay	$20 copay	Covered in full	Covered in full	$20 copay	$20 copay	Not covered
Preventive Services — Routine Physical, Well-Baby Care, Pediatric Exams, Childhood Immunizations	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Not covered
Vision and Hearing Examinations	$20 copay	Vision exam not covered; Hearing exam covered	Vision exam not covered; Hearing exam covered every 36 months	Vision exam not covered; Hearing exam covered every 36 months	Not covered	Vision exam not covered; Hearing exam covered	Vision exam not covered; Hearing exam covered at **participating** providers
Urgent Care	$20 copay	$20 copay	$20 copay	$40 copay	$20 copay	$20 copay	$20 copay
Emergency Room Services	$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies. Must notify medical plan within 48 hours of admission.	$100 copay (waived if admitted). Covers life-threatening or accidental medical emergencies. Must notify medical plan within 48 hours of admission.	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies.	$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies.	$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies.
Laboratory, Pathology and Radiology (X-Ray) Services	Covered in full	Covered in full	Covered in full	20% coinsurance after deductible	Plan pays 90% after deductible (preventive services excluded)	Covered in full	80% after out-of-network deductible
Allergy Testing and Injections	Covered in full	Covered in full	Covered in full	Covered in full	$20 copay	Covered in full	80% after out-of-network deductible
Outpatient Physical, Speech and Occupational Therapy	Covered in full (up to 60 combined visits per year)	Office visit copay applies (up to 60 visits per medical episode per year)	$20 copay; Maximum 30 visits per member per year, combined Tier 1 & Tier 2	$40 copay after deductible; Maximum 30 visits per member per year, combined Tier 1 & Tier 2	Plan pays 90% after deductible	Covered in full (up to 60 visits per year combined with out of network)	80% after out-of-network deductible at **participating** providers
Durable Medical Equipment	Covered in full for approved equipment	Covered in full	Covered in full	50% coinsurance after deductible	Plan pays 90% after deductible	Covered in full	Covered in full
Chiropractic Services/ Spinal Manipulation	Not covered	Office visit copay applies (referral required)	$20 copay; Maximum 30 visits per member per year, combined Tier 1 & Tier 2	$40 copay after deductible; Maximum 30 visits per member per year, combined Tier 1 & Tier 2	Plan pays 90% after deductible (up to 38 visits per year)	Covered in full (up to 24 visits per year)	80% after out-of-network deductible (up to 24 visits per year)
Reproductive Care							
Pre-Natal Care	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	80% after out-of-network deductible
Delivery and Routine Nursery Care	Covered in full	Covered in full	Covered in full	20% coinsurance after deductible	Plan pays 90% after deductible	Covered in full	80% after out-of-network deductible
Infertility Services	Coverage is limited to services for diagnosis, counseling, and treatment of bodily disorders causing infertility	Coverage is limited to diagnosis, counseling and treatment of infertility. Coverage includes artificial insemination for the treatment of infertility	Coverage is limited to diagnostic, counseling, and planning services for treatment of the underlying cause of infertility		Coverage is limited to services that treat the medical condition of infertility	Coverage is limited to services that treat the medical condition of infertility	Coverage is limited to services that treat the medical condition of infertility
Voluntary Sterilization	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full (female only)	Covered in full	80% after out-of-network deductible

Benefit Plan Comparison - Plan 1	Health Alliance Plan In-Network Only	Blue Care Network In-Network Only	Priority Health		Traditional BCBSM	BCBSM PPO (formerly Community Blue)	
			Tier 1 In-Network Only	Tier 2 In-Network Only		In-Network	Out-of-Network
Mental Health and Substance Abuse							
Outpatient Care: In Person	$20 copay	$20 copay	$20 copay	$40 copay	Plan pays 90% after deductible	Covered in full (approved facilities)	Covered in full (approved facilities)
Telemedicine/Virtual Visits	Not covered	$20 copay	Covered in full	Covered in full	Plan pays 90% after deductible	$20 copay	80% after out-of-network deductible
Inpatient Care	Covered in full	Covered in full	Covered in full	20% coinsurance after deductible	Plan pays 90% after deductible	Covered in full	80% after out-of-network deductible
Prescription Drugs							
Prescription Drugs	$5 generic drugs $20 preferred brand drugs $45 non-preferred brand drugs (copay waived forgeneric oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available.	$5 generic drugs $20 preferred brand drugs $45 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available.	$5 generic drugs $20 preferred brand drugs $45 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available.		$5 generic drugs $20 preferred brand drugs $45 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available.	$5 generic drugs $20 preferred brand drugs $45 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available.	75% of approved amount less plan copay. Limited to one month supply. Includes contraceptive medications.
Other Services							
Autism Spectrum Disorder	Covered — contact carrier for details	Covered — contact carrier for details	Covered - contact carrier for details	Covered - contact carrier for details	Covered — contact carrier for details	Covered — contact carrier for details	Covered — contact carrier for details
Eyeglasses and Contact Lenses	Covered following cataract or intra-ocular surgery	Covered following cataract or intra-ocular surgery	Not covered	Not covered	Covered following cataract or intra-ocular surgery, accidental injury, or certain non-routine diagnoses. Plan pays 90% after deductible.	Covered following catarct surgery	Not covered
Hearing Aids	Covered for authorized conventional hearing aids	Covered (one hearing aid every 36 months)	$500 allowance per hearing aid every 36 months	$500 allowance per hearing aid every 36 months	Not covered	Covered (one hearing aid every 36 months)	Not covered
Skilled Nursing Care Facility (excluding custodial care)	Covered in full (730 days, renewable after 60 days of nonconfinement)	Covered in full (730 days in a lifetime)	Covered in full (45 days covered per member each contract year)	20% coinsurance after deductible (45 days covered per member each contract year)	Not covered	Covered in full (120 days per calendar year)	Covered in full (120 days per calendar year)
Deductibles, Copays, and Limitations							
Annual Deductible	No deductible	No deductible	No deductible	$2,000 per individual $4,000 per family Deductible costs don't apply towards your coinsurance maximum.	$100 per individual $200 maximum per family	No deductible	$250 per individual $500 per family
Annual Coinsurance Maximum	N/A	N/A	N/A	20% coinsurance for services after deductible is met, except where noted.	$500 per individual $1,000 per family	N/A	$2,000 per individual $4,000 per family
Annual Out-of-Pocket Maximum (includes deductible, coinsurance & copays)	$6,350 per individual $12,700 per family	$6,350 per individual $12,700 per family	N/A	$6,350 per individual $12,700 per family	$600 per individual $1,200 per family	$600 per individual $1,200 per family	$2,250 per individual $4,500 per family
Hospital Precertification	Required for admission in a non-participating hospital within 48 hours	Required for admission in a non-participating hospital within 48 hours	Required at least 5 working days in advance	Required at least 5 working days in advance	Required — provider responsibility	Required — provider responsibility	Required — provider responsibility

Benefit Plan Comparison - Plan 2	Health Alliance Plan In-Network Only	Blue Care Network In-Network Only	Priority Health		Traditional BCBSM	BCBSM PPO (formerly Community Blue)	
			Tier 1 In-Network Only	Tier 2 In-Network Only		In-Network	Out-of-Network
Inpatient Hospital							
Hospital Services	Covered after deductible	Covered in full after deductible	Covered in full after deductible	20% coinsurance after deductible	Plan pays 90% after deductible (non-emergency services must be rendered in a **participating** hospital)	Covered in full after deductible (non-emergency services must be rendered in a **participating** hospital)	80% after out-of-network deductible (non-emergency services must be rendered in a **participating** hospital)
Medical Care							
Office Visits: In Person	$20 PCP copay; $30 specialist copay	$20 PCP copay; $30 specialist copay	$20 PCP copay; $30 specialist copay	$40 PCP copay; $60 specialist copay	$20 PCP copay; $30 specialist copay	$20 PCP copay; $30 specialist copay	80% after out-of-network deductible
Telemedicine/Virtual Visits	$20 copay	$20 copay	Covered in full	Covered in full	$20 PCP copay; $30 specialist copay	$20 PCP copay; $30 specialist copay	80% after out-of-network deductible
Preventive Services — Routine Physical, Well-Baby Care, Pediatric Exams, Childhood Immunizations	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Not covered
Vision and Hearing Examinations	Covered in full	Vision exam not covered; Hearing exam covered every 36 months	Vision exam not covered; Hearing exam covered every 36 months	Vision exam not covered; Hearing exam covered every 36 months	Not covered	Vision exam not covered; Hearing exam covered every 36 months	Vision exam not covered; Hearing exam covered at **participating** providers every 36 months
Urgent Care	$30 copay	$30 copay	$30 copay	$60 copay	Plan pays 90% after deductible	$30 copay	80% after out-of-network deductible
Emergency Room Services	$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies. Must notify medical plan within 48 hours of admission.	$100 copay (waived if admitted). Covers life-threatening or accidental medical emergencies. Must notify medical plan within 48 hours of admission.	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies.	$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies.	$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies.
Laboratory, Pathology and Radiology (X-Ray) Services	Covered after deductible	Lab & pathology covered in full; Diagnostic tests & X-rays covered in full after deductible	Covered in full after deductible	20% coinsurance after deductible	Plan pays 90% after deductible	Covered in full after deductible	80% after out-of-network deductible
Allergy Testing and Injections	Covered after deductible	Covered in full after deductible	Covered in full	Covered in full	$20 PCP copay; $30 specialist copay	Covered in full after deductible	80% after out-of-network deductible
Outpatient Physical, Speech and Occupational Therapy	Covered after deductible	$30 copay; 60 visits per medical episode per plan year	$20 copay; Maximum 30 visits per member per year, combined Tier 1 & Tier 2	$40 copay; Maximum 30 visits per member per year, combined Tier 1 & Tier 2	Plan pays 90% after deductible	Covered in full after deductible (up to 60 visits per year combined with out-of network)	80% after out-of-network deductible at **participating** providers
Durable Medical Equipment	Covered after deductible for approved equipment	Covered in full	Covered in full after deductible	50% coinsurance after deductible	Plan pays 90% after deductible	Covered in full after deductible	Covered in full after out-of-network deductible
Chiropractic Services/ Spinal Manipulation	Not covered	$30 copay	$20 copay; Maximum 30 visits per member per year, combined Tier 1 & Tier 2	$40 copay; Maximum 30 visits per member per year, combined Tier 1 & Tier 2	Plan pays 90% after deductible (up to 38 visits per year)	Covered in full after deductible (up to 24 visits per year combined with out-of network)	80% after out-of-network deductible (up to 24 visits per year)
Reproductive Care							
Pre-Natal Care	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	80% after out-of-network deductible
Delivery and Routine Nursery Care	Covered after deductible	Covered in full after deductible	Covered in full after deductible	20% coinsurance after deductible	Plan pays 90% after deductible	Covered in full after deductible	80% after out-of-network deductible
Infertility Services	Coverage is limited to services for diagnosis, counseling, and treatment of bodily disorders causing infertility	Coverage is limited to diagnosis, counseling and treatment of infertility. Coverage includes artificial insemination for the treatment of infertility	Coverage is limited to diagnostic, counseling, and planning services for treatment of the underlying cause of infertility		Coverage is limited to services that treat the medical condition of infertility	Coverage is limited to services that treat the medical condition of infertility	Coverage is limited to services that treat the medical condition of infertility
Voluntary Sterilization	Covered in full - female Covered after deductible - male	Covered in full - female Covered after deductible - male	Covered in full - male & female	Covered in full - male & female	Covered in full (female only)	Covered in full - female Covered after deductible - male	80% after out-of-network deductible

Benefit Plan Comparison - Plan 2	Health Alliance Plan In-Network Only	Blue Care Network In-Network Only	Priority Health		Traditional BCBSM	BCBSM PPO (formerly Community Blue)	
			Tier 1 In-Network Only	Tier 2 In-Network Only		In-Network	Out-of-Network
Mental Health and Substance Abuse							
Outpatient Care: In Person	$20 copay	$20 copay	$20 copay	$40 copay	Plan pays 90% after deductible	Covered in full after deductible (approved facilities)	80% after out-of-network deductible
Telemedicine/Virtual Visits	Not covered	$20 copay	Covered in full	Covered in full	$20 copay	$20 copay	Not covered
Inpatient Care	Covered after deductible	Covered in full after deductible	Covered in full after deductible	20% coinsurance after deductible	Plan pays 90% after deductible	Covered in full after deductible	80% after out-of-network deductible
Prescription Drugs							
Prescription Drugs	$10 generic drugs $25 preferred brand drugs $55 non-preferred brand drugs (copay waived forgeneric oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available.	$10 generic drugs $25 preferred brand drugs $55 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available.	$10 generic drugs $25 preferred brand drugs $55 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available.		$10 generic drugs $25 preferred brand drugs $55 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available.	$10 generic drugs $25 preferred brand drugs $55 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available.	75% of approved amount less plan copay. Limited to one month supply. Includes contraceptive medications.
Other Services							
Autism Spectrum Disorder	Covered — contact carrier for details	Covered — contact carrier for details	Covered — contact carrier for details	Covered — contact carrier for details	Covered — contact carrier for details	Covered — contact carrier for details	Covered — contact carrier for details
Eyeglasses and Contact Lenses	Covered following cataract or intra-occular surgery	Covered following cataract or intra-occular surgery	Not covered	Not covered	Covered following cataract or intra-ocular surgery, accidental injury, or certain non-routine diagnoses. Plan pays 90% after deductible.	Covered following cataract or intra-occular surgery	Not covered
Hearing Aids	Covered for authorized conventional hearing aids; deductible does not apply	Covered (one hearing aid every 36 months)	$500 allowance per hearing aid every 36 months	$500 allowance per hearing aid every 36 months	Not covered	Covered (one hearing aid every 36 months)	Not covered
Skilled Nursing Care Facility (excluding custodial care)	Covered after deductible	Covered in full after deductible	Covered in full after deductible (45 days covered per member each year)	20% coinsurance after deductible (45 days covered per member each year)	Not covered	Covered in full after deductible (120 days per calendar year)	Covered in full (120 days per calendar year)
Deductibles, Copays, and Limitations							
Annual Deductible	$100 per individual $200 per family	$100 per individual $200 per family	$100 per individual $200 per family	$2,000 per individual $4,000 per family	$100 per individual $200 maximum per family	$100 per individual $200 maximum per family	$250 per individual $500 per family
Annual Coinsurance Maximum	N/A	N/A	N/A	N/A	$500 per individual $1,000 per family	N/A	$2,000 per individual $4,000 per family
Annual Out-of-Pocket Maximum (includes deductible, coinsurance & copays)	$6,350 per individual $12,700 per family	$6,350 per individual $12,700 per family	$6,350 per individual $12,700 per family	$6,350 per individual $12,700 per family	$600 per individual $1,200 per family	$600 per individual $1,200 per family	$2,250 per individual $4,500 per family
Hospital Precertification	Required for admission in a non-participating hospital within 48 hours	Required for admission in a non-participating hospital within 48 hours	Required at least 5 working days in advance	Required at least 5 working days in advance	Required — provider responsibility	Required — provider responsibility	Required — provider responsibility