

Broward Sheriff's Office - 2011 HMO Medical Benefits and Proposed Alternative Plan Designs - October 21, 2011 Alternate I				
Plan Name Referrals are not required for Covered Services (*)	Current HMO Premier Plan (Gated) 13044	Proposed Alternative HMO GATED \$200 15/25 13044-6	Current HMO Open Access Plan 13043	Proposed Alternative HMO Focused Deductible Open Access (*) Premier Plan 13042-1d 20/40
Employee Monthly Contribution	\$21.00 Single/\$60.00 Family	\$21.00 Single/\$60.00 Family	\$0 Single/\$0 Family	\$0 Single/\$0 Family
ID Card Description	BSO Premier HMO	BSO Premier HMO	BSO Open Access HMO	BSO Open Access HMO
Annual Deductible (Individual/Family) (per calendar year) (Unless otherwise noted any benefit not subject to copayment is subject to deductible)	\$100 / \$200	\$200 / \$400	\$150 / \$300	\$300/ \$600 (per calendar year; applies to all inpatient and outpatient services at hospital)
Maximum Copayment (Individual/Family) (per calendar year) (Maximum does not include deductible)	\$1,500 / \$3,000	\$2,000 / \$4,000	\$1,500 / \$3,000	\$2000/\$4000
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Outpatient Physician Services				
Adult Preventive Care (includes annual physical exams, annual well-woman exams, Pap smears, prostate cancer screening, colon cancer screening, eye exams, health education and counseling and immunizations)	Covered at 100% NO Deductible	Covered at 100% NO Deductible	Covered at 100% NO Deductible	Covered at 100% NO Deductible
Child Preventive Care (includes well child and well baby exams and immunizations)	Covered at 100% NO Deductible	Covered at 100% NO Deductible	Covered at 100% NO Deductible	Covered at 100% NO Deductible
Routine Mammogram (based on established guidelines)	Covered at 100% NO Deductible	Covered at 100% NO Deductible	Covered at 100% NO Deductible	Covered at 100% NO Deductible
Primary Care Physician (PCP Office Visits)	\$15 Copay	\$15 Copay	\$15 Copay	\$15 Copay
Specialist Physician Office Visits	\$20 Copay	\$25 Copay	\$25 Copay	\$30 Copay
Chiropractic and Podiatry Services - per visit	\$15 PCP; \$20 Specialist	\$15 PCP; \$25 Specialist	\$15 PCP; \$25 Specialist	\$15 PCP; \$30 Specialist Non-Surgical Spine and Back Services 20 visits per calendar year
Allergy injections at a PCP or Specialist office	No copay after Deductible	No copay after Deductible	No copay after Deductible	No copay after Deductible
Physician services provided in an Emergency Room and physicians visits while confined	No copay after Deductible	No copay after Deductible	No copay after Deductible	No copay after Deductible
Maternity Prenatal and Postnatal Care in a Physician's office	One-time \$20 Copay	One-time \$25 Copay	One-time \$25 Copay	One-Time \$30 Copay
Maternity Prenatal and Postnatal Care in a Sub-Specialty office	\$20 Copay	\$25 Copay	\$25 Copay	\$30 Copay
Second Medical & Surgical Opinion by Participating Physician	\$20 Copay	No copay after Deductible	No copay after Deductible	\$15 PCP; \$30 Specialist
Second Medical & Surgical Opinion by Non-Participating Physician	40% of Allowed Amount	40% of Allowed Amount	40% of Allowed Amount	40% of Allowed Amount
Inpatient Hospital/Physician Services				
Inpatient Hospital Facility Services (includes pre-admission testing, room & board, general nursing services, specialist consultation, physician visits, use of intensive care and specialty care units, x-rays, diagnostics/labs, operating and recovery rooms, anesthesia and anesthesiologist services, radiation therapy & chemotherapy, rehabilitative services, surgeon services, specialist consultation, physician visits, human organ transplants)	\$150 copay per admission	\$300 copay per admission after deductible	\$300 copay per admission	After Hospital Deductible: \$100/day for the first 1x5 days
Labor and delivery in a hospital or birthing center	\$150 copay per admission	\$300 copay per admission after deductible	\$300 copay per admission	After Hospital Deductible: \$100/day for the first 1x5 days
Inpatient Neonatal Intensive Care Unit (NICU) (admission and subsequent inpatient care)	\$150 copay per admission	\$300 copay per admission after deductible	\$300 copay per admission	After Hospital Deductible: \$100/day for the first 1x5 days
Outpatient Medical Services				
Outpatient Diagnostic Services at a Hospital	\$50 copay per occurrence	\$75 copay per occurrence after deductible	\$50 copay per occurrence	After Hospital Deductible: \$80 Copay
Outpatient Diagnostic Services at a Diagnostic Center	No copay; NO deductible	\$25 copay	\$25 copay per occurrence	\$30 Copay
Outpatient Diagnostic Services in a Physician's office	No additional copay	No additional copay	No additional copay	No additional copay
Outpatient Surgery at a Hospital (including physician and facility services)	\$100 per occurrence	\$150 copay per occurrence after deductible	\$150 per occurrence	After Hospital Deductible: \$150 Copay
Outpatient Surgery at an Ambulatory Surgical Center (including physician and facility services)	\$50 copay per occurrence	\$100 copay per occurrence	\$75 copay per occurrence	\$100 Copay
Outpatient Surgery Services in a Physician's office	No additional copay	No additional copay	No additional copay	No additional copay

Broward Sheriff's Office - 2011 HMO Medical Benefits and Proposed Alternative Plan Designs - October 21, 2011 Alternate I				
Plan Name Referrals are not required for Covered Services (*)	Current HMO Premier Plan (Gated) 13044	Proposed Alternative HMO GATED \$200 15/25 13044-6	Current HMO Open Access Plan 13043	Proposed Alternative HMO Focused Deductible Open Access (*) Premier Plan 13042-1d 20/40
Twenty three hour hospital admissions for medical observations, diagnostic or surgical stays	No copay after Deductible	No copay after Deductible	No copay after Deductible	After Hospital Deductible: No Copay
Outpatient Radiation and Chemotherapy	No copay after Deductible	No copay after Deductible	No copay after Deductible	After Hospital Deductible: \$30 Copay at Hospital \$30 Copay at Freestanding Facility
Outpatient Physical, Speech, Occupational & Respiratory Therapy	No copay after Deductible	\$25 copay	\$25 Copay	Physical, Speech and Occupational Therapy After Hospital Deductible: \$30 Copay at Hospital \$30 Copay at Freestanding Facility
Limitation:	60 visits per calendar year; combined for all therapies	60 visits per therapy type; per calendar year	60 visits per calendar year; combined for all therapies	60 visits per therapy type; per calendar year
Outpatient Cardiac Therapy	No copay after Deductible	No copay after Deductible	No copay after Deductible	Cardiac and Respiratory Therapy After Hospital Deductible: \$30 Copay at Hospital \$30 Copay at Freestanding Facility
Outpatient Dialysis	No copay after Deductible	No copay after Deductible	No copay after Deductible	After Hospital Deductible:\$30 Copay per treatment \$30 Copay per treatment at Freestanding Facility
Skilled Nursing, Home Health and Hospice Care Services				
Skilled Nursing Facility Care/Rehabilitation Center	No copay after Deductible	No copay after Deductible	No copay after Deductible	\$50/day for the first 1-2 days of each admission
Home Health Care Services	\$20 copay per visit	No copay after Deductible	No copay after Deductible	No Copay
Hospice (210 days per lifetime)	No copay after Deductible	No copay after Deductible	No copay after Deductible	No Copay
Emergency and Urgent Care Services				
Emergency Care at Hospital Emergency Room-In the service area in a participating/non-participating hospital (waived if admitted)	\$150 Copay	\$200 Copay	\$150 Copay	\$200 Copay
Emergency Care at Hospital Emergency Room-Outside the service area in a non-participating hospital (waived if admitted)	\$150 Copay	\$200 Copay	\$150 Copay	\$200 Copay
Emergency Care in Participating physician's office	\$15 PCP; \$20 Specialist	\$15 PCP; \$25 Specialist	\$15 PCP; \$25 Specialist	\$15 PCP; \$30 Specialist
Ambulance Services	No copay after Deductible	No copay after Deductible	No copay after Deductible	No Copay
Urgent Care Center	\$20 Copay	\$25 Copay	\$25 Copay	\$30 Copay
Convenient Care Clinic Services	\$15 Copay	\$15 Copay	\$15 Copay	\$15 Copay
Mental Health Services				
Inpatient Treatment	\$50 copay per admission	\$300 copay per admission	\$300 copay per admission	After Hospital Deductible: \$100/day for the first 1x5 days
Outpatient Treatment	No copay after deductible	\$15 Copay	\$15 Copay	\$30 Copay
Substance Abuse Services				
Inpatient Detoxification & Rehabilitation	\$50 copay per admission	\$300 copay per admission	\$300 copay per admission	Inpatient Detoxification-After Hospital Deductible: \$100/day for the first 1-2 days Inpatient Rehabilitation-After Hospital Deductible;\$100/day for the first 1-2 days
Outpatient Rehabilitation Treatment	No copay after deductible	\$15 Copay	\$15 Copay	\$30 Copay
Family Planning Services				

Broward Sheriff's Office - 2011 HMO Medical Benefits and Proposed Alternative Plan Designs - October 21, 2011 Alternate I				
Plan Name	Current	Proposed Alternative	Current	Proposed Alternative
Referrals are not required for Covered Services (*)	HMO Premier Plan (Gated) 13044	HMO GATED \$200 15/25 13044-6	HMO Open Access Plan 13043	HMO Focused Deductible Open Access (*) Premier Plan 13042-1d 20/40
Infertility Services	(Counseling, Testing & Treatment) Coverage is 100% after deductible for the first \$2,000 of allowed amount then 50% of reasonable costs thereafter in an office	Infertility related services \$25 Copay-in an office (Limited to \$15,000 benefit maximum)	OV \$25 copay; \$300 Copay per admission; \$10,000 maximum benefit	Voluntary Counseling-\$30 Copay Infertility related services-\$30 Copay (Limited to \$15,000 benefit maximum)
Medically Necessary/Elective Abortion	Elective-Not Covered	Elective-Not Covered	Elective-Not Covered	Elective-Not Covered
Elective Sterilization	\$100 Copay	\$100 Copay	\$100 Copay	After Hospital Deductible: \$200 Copay at Hospital \$200 Copay at Freestanding Facility
Intrauterine Devices (IUD) (device, insertion, removal)	\$15 PCP;\$20 Specialist	\$15 PCP; \$25 Specialist	\$15 PCP;\$25 Specialist	\$15 PCP; \$30 Specialist
Other Covered Services				
Durable Medical Equipment	No copay after Deductible	No copay after Deductible	No copay after Deductible	No Copay
Breast Prosthetics and other External Orthotics/Prosthetics	No copay after Deductible	No copay after Deductible	No copay after Deductible	No Copay
Hearing Aids (other than cochlear implants)	Not Covered	Not Covered	Not Covered	Not Covered
Insulin	Applicable RX copay per prescription	Applicable RX copay per prescription	Applicable RX copay per prescription	Applicable RX copay per prescription
Diabetic Supplies (includes glucose monitors, test strips,lancets, etc)	No copay; NO deductible	No copay; NO deductible	No copay; NO deductible	No copay; NO deductible
Testing for Learning Disabilities (for children 5 years and older)	\$200 Copay	\$200 Copay	\$200 Copay	\$200 Copay
Circumcision in a Hospital prior to postnatal discharge	No additional copay	No additional copay	No additional copay	No additional copay
Circumcision in a Physician's office	\$15 PCP;\$20 Specialist	\$15 PCP; \$25 Specialist	\$15 PCP;\$25 Specialist	\$15 PCP; \$30 Specialist
Circumcision in a Hospital after postnatal discharge	See outpatient surgery copay	See outpatient surgery copay	See outpatient surgery copay	Same as outpatient surgery copay
Prescription Drug Coverage 30-day supply (2)	Tier 1 - \$5; MO: \$10 Tier 2 - \$15; MO: \$30 Tier 3 - \$30; MO: \$60	Tier 1 - \$10; MO: \$20 Tier 2 - \$25; MO: \$50 Tier 3 - \$50; MO: \$100 Tier 4 - 20% to a maximum of \$250 per month out-of-pocket (except for diabetic supplies); MO: not applicable	Tier 1 - \$10; MO: \$20 Tier 2 - \$25; MO: \$50 Tier 3 - \$40; MO: \$80 Tier 4 - 20% to a maximum of \$250 per month out-of-pocket (except for diabetic supplies); MO: not applicable	Tier 1 - \$10; MO: \$20 Tier 2 - \$25; MO: \$50 Tier 3 - \$50; MO: \$100 Tier 4 - 20% to a maximum of \$250 per month out-of-pocket (except for diabetic supplies); MO: not applicable
Mail Order (MO) 90-day supply)				
Self-Injectables	Applicable RX copay; MO not applicable	Refer to Tier 4 listed above	Refer to Tier 4 listed above	Refer to Tier 4 listed above
(*) PCP referrals are not required for Covered Services, however certain Covered Services require Prior Authorization. Please refer to the Certificate of Coverage for further details on Prior Authorization requirements.				
(2) If you or your physician request a brand name medication when a generic is available, you must pay 100% of the difference in price between the generic and brand name medication plus the applicable brand copayment. Rx coverage tiering is Tier 1/Tier 2/Tier 3/Tier 4 Self-Injectables. Insulin & Diabetic supplies are covered as part of the Prescription drug benefit. Prescription drug copayments do not apply toward the Out-of-Pocket Maximum.				

Broward Sheriff's Office - 2011 POS Medical Benefits and Alternative Plan Designs - Oct. 21, 2011 Alternate I

Plan Name	Current POS - Premier Plus (Gated) 13470		Proposed Alternative POS Premier Plus (Gated) 13471-1a	
Employee Contribution	\$35.32 Single/\$114.80 Family		\$35.32 Single/\$114.80 Family	
ID Card Description	BSO 2011 Prem Plus		BSO POS	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Individual/Family) (per calendar year) (Unless otherwise noted any benefit not subject to copayment is subject to deductible)	\$100 / \$200	\$250 / \$500	\$250 / \$500	\$300 / \$600
Annual Out-of-Pocket Maximum (Individual/Family) Maximum does not include deductible	None	\$2,500 / \$5,000	\$2,500 / \$5,000	None
Lifetime Maximum Benefit	Unlimited		Unlimited	
Outpatient Physician Services				
Adult Preventive Care (includes annual physical exams, annual well-woman exams, Pap smears, prostate cancer screening, colon cancer screening, eye exams, health education and counseling and immunizations)	Covered at 100%	30%; NO deductible	Covered at 100%	30%; NO deductible
Child Preventive Care (includes well child and well baby exams and immunizations)	Covered at 100%	30%; NO deductible	Covered at 100%	30%; NO deductible
Routine Mammogram (based on established guidelines)	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Primary Care Physician (PCP Office Visits)	\$20 Copay	30% after deductible	\$20 Copay	30% after deductible
Specialist Physician Office Visits	\$25 Copay	30% after deductible	\$40 Copay	30% after deductible
Diagnostic testing, x-rays, laboratory tests and allergy testing provided in the physician's office	No additional copay	30% after deductible	No additional copay	30% after deductible
Allergy injections at PCP or Specialist	No Copay after deductible	30% after deductible	No Copay after deductible	30% after deductible
Chiropractic and Podiatry Services	\$20 PCP; \$25 Specialist	30% after deductible	\$20 PCP; \$40 Specialist	30% after deductible
Maternity Prenatal and Postnatal Care	One-time \$25 Copay	30% after deductible	One-time \$40 Copay	30% after deductible
Second Medical & Surgical Opinion	\$25 Copay	30% after deductible	\$40 Copay	30% after deductible
Inpatient Hospital/Physician Services				
Inpatient Hospital Facility Services (includes pre-admission testing, room & board, general nursing services, specialist consultation, physician visits, use of intensive care and specialty care units, x-rays, diagnostics/labs, operating and recovery rooms)	\$200 Copay per admission	30% after deductible plus \$500 copay per admission	\$300 Copay per admission after deductible	30% after deductible plus \$500 copay per admission
Inpatient Neonatal Intensive Care Unit (NICU) (admission and subsequent inpatient care)	\$200 Copay per admission	30% after deductible plus \$500 copay per admission	\$300 Copay per admission after deductible	30% after deductible plus \$500 copay per admission
Hospital visits inpatient and outpatient)	No additional copay	30% after deductible	No additional Copay	30% after deductible
Outpatient Services				
Outpatient Surgery at a Hospital	\$100 Copay per occurrence	30% after deductible	\$150 Copay per occurrence after deductible	30% after deductible
Outpatient Surgery at an Ambulatory Surgical Center	\$50 Copay per occurrence	30% after deductible	\$50 Copay per occurrence	30% after deductible
Outpatient Non-Surgical Care at a Hospital	\$50 Copay per occurrence	30% after deductible	\$50 Copay per occurrence after deductible	30% after deductible
Outpatient Non-Surgical Care at a Freestanding Facility	No Copay; NO deductible	30% after deductible	\$25 Copay; NO deductible	30% after deductible
Outpatient Physical, Speech and Occupational Therapy at a Hospital (1)	No Copay after deductible	30% after deductible	No Copay after deductible	30% after deductible
Outpatient Physical, Speech and Occupational Therapy at a Freestanding Facility (1)	No Copay after deductible	30% after deductible	No Copay after deductible	30% after deductible
Outpatient Cardiac and Respiratory Therapy	No Copay after deductible	30% after deductible	No Copay after deductible	30% after deductible
Outpatient Radiation and Chemotherapy	No Copay after deductible	30% after deductible	No Copay after deductible	30% after deductible
Outpatient Dialysis Services	No Copay after deductible	30% after deductible	No Copay after deductible	30% after deductible
Twenty three hour hospital admissions for medical observations, diagnostic or surgical stays	No Copay after deductible	30% after deductible	No Copay after deductible	30% after deductible

Broward Sheriff's Office - 2011 POS Medical Benefits and Alternative Plan Designs - Oct. 21, 2011 Alternate I

Plan Name	Current POS - Premier Plus (Gated) 13470		Proposed Alternative POS Premier Plus (Gated) 13471-1a	
Employee Contribution	\$35.32 Single/\$114.80 Family		\$35.32 Single/\$114.80 Family	
ID Card Description	BSO 2011 Prem Plus		BSO POS	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Skilled Nursing, Home Health and Hospice Care Services				
Skilled Nursing Facility Care/Rehabilitation Center (120 days per calendar year)	No Copay after deductible	30% after deductible	No Copay after deductible	30% after deductible
Home Health Care Services	No Copay after deductible	30% after deductible	No Copay after deductible	30% after deductible
Hospice Care (210 days lifetime)	No Copay after deductible	30% after deductible	No Copay after deductible	30% after deductible
Emergency and Urgent Care Services				
Emergency Care at Hospital Emergency Room (waived if admitted)	\$150 Copay	\$150 Copay	\$200 Copay	\$200 Copay
Emergency Services in Physician's office	100% coverage after \$20 Copay	30% after deductible	100% coverage after \$20 Copay	30% after deductible
Urgent Care Center	\$25 Copay	30% after deductible	\$40 Copay	30% after deductible
Convenient Care Clinic Services	\$20 Copay	30% after deductible	\$20 Copay	30% after deductible
Ambulance services to hospital (emergency only)	No Copay after deductible	30% after deductible	No Copay after deductible	30% after deductible
Mental Health Services				
Inpatient Treatment	\$50 Copay per admission	30% after deductible plus \$500 copay per admission	\$300 Copay per admission after deductible	30% after deductible plus \$500 copay per admission
Outpatient Treatment	No Copay after deductible	30% after deductible	No Copay after deductible	30% after deductible
Substance Abuse Services				
Inpatient Detoxification & Rehabilitation	\$50 Copay per admission	30% after deductible plus \$500 copay per admission	\$300 Copay per admission after deductible	30% after deductible plus \$500 copay per admission
Outpatient Rehabilitation Treatment	No Copay after deductible	30% after deductible	No Copay after deductible	30% after deductible
Family Planning Services				
Infertility Services	Only Counseling and Testing is covered		Only Counseling and Testing is covered	
Infertility Treatment	Not Covered		Not Covered	
Medically Necessary/Elective Abortion	Elective Not Covered		Elective Not Covered	
Elective Sterilization	\$100 Copay	30% after deductible	\$100 Copay	30% after deductible
Intrauterine Devices (IUD) (device, insertion, removal)	\$20 PCP; \$25 Specialist	30% after deductible	\$20 PCP; \$40 Specialist	30% after deductible
Other Covered Services				
Durable Medical Equipment	No Copay after deductible	30% after deductible	No Copay after deductible	30% after deductible
Breast Prosthetic and other External Orthotics/Prosthetics	No Copay after deductible	30% after deductible	No Copay after deductible	30% after deductible
Hearing Aids (other than cochlear implants)	Not Covered		Not Covered	
Insulin	Applicable RX Copay per prescription	30% after deductible	Applicable RX Copay per prescription	30% after deductible
Diabetic Supplies (includes glucose monitors, test strips, lancets, etc)	No Copay; NO deductible	30% after deductible	No Copay; NO deductible	30% after deductible
Prescription Drug Coverage 30-day supply (2)	Tier 1 - \$5; MO: \$10 Tier 2 - \$15; MO: \$30 Tier 3 - \$30; MO: \$60	30% after deductible	Tier 1 - \$10; MO: \$20 Tier 2 - \$25; MO: \$50 Tier 3 - \$50; MO: \$100 Tier 4 - 20% to a maximum of \$250 per month out-of-pocket; MO: not applicable	30% after deductible
Mail Order (MO) 90-day supply)			Refer to Tier 4 listed above	Not Covered
Self-Injectables	Applicable RX Copay; MO not applicable	30% after deductible; MO not covered		Not Covered

(1) Outpatient Physical, Speech and Occupational Therapy - Limited to 60 visits per therapy type; per calendar year

(2) If you or your physician request a brand name medication when a generic is available, you must pay 100% of the difference in price between the generic and brand name medication plus the applicable brand copayment. Rx coverage tiering is Tier 1/Tier 2/Tier 3/Tier 4-5 injectables. Insulin& diabetic supplies are covered as part of the Prescription drug benefit. Prescription drug copayments do not apply toward the out-of-pocket maximum.

Broward Sheriff's Office - 2011 PPO Medical Benefits and Alternative Plan Designs - Oct. 21, 2011 Alternate I

Plan Name	Current PPO 13342 -In Area (*) 13343 -Out-of-Area		Proposed Alternative PPO 13342-1a - In Area (*) 13343-2a - Out-of-Area	
Employee Contribution	\$64.75 Single/\$189.00 Family		\$64.75 Single/\$189.00 Family	
ID Card Description	BSO LG PPO 2011 / BSO LG PPO OOA 11		BSO PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Individual/Family) (per calendar year) (eligible expenses, regardless of where they are incurred, apply toward both the in-network and out-of-network annual deductible)	\$250 / \$500	\$350 / \$700	\$250 / \$500	\$350 / \$700
Coinsurance (the sharing of expenses for Covered Services between Coventry and the Member)	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Out-of-Pocket Maximum (Individual/Family) (per calendar year) (maximum amount of coinsurance a Member will pay; prescription drugs do not apply toward the maximum) (eligible expenses, regardless of where they are incurred, apply toward both in-network and out-of-network maximum)	\$1,450 / \$2,900	\$2,895 / \$5,790	\$2,500 / \$5,000	\$5,000 / \$10,000
Lifetime Maximum Benefit	Unlimited		Unlimited	
Outpatient Physician Services				
Adult Preventive Care (includes annual physical exams, annual well-woman exams, Pap smears, prostate cancer screening, colon cancer screening, eye exams, health education and counseling and immunizations)	Covered at 100%	100% Coverage; NO deductible	Covered at 100%	100% Coverage; NO deductible
Child Preventive Care (includes well child and well baby exams and immunizations)	Covered at 100%	30%; NO deductible	Covered at 100%	30%; NO deductible
Routine Mammogram (based on established guidelines)	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Physician office visits (includes diagnostic laboratory and radiology, surgery including anesthesia, prenatal and postnatal care, allergy testing, second surgical opinions)	\$15 Copay	30% after deductible	\$15 Copay	30% after deductible
Chiropractic and Podiatry Services	\$15 Copay	30% after deductible	\$15 Copay	30% after deductible
Allergy injections	Covered at 100%	30% after deductible	Covered at 100%	30% after deductible
Inpatient Hospital/Physician Services				
Inpatient Hospital Facility Services (includes pre-admission testing, room & board, diagnostic tests, x-rays, operating & recovery room, intensive & special care units, general nursing care, anesthesia, prescribed drugs, radiation & chemotherapy, surgeon services, anesthesiologist services, specialist consultation, physician visits, human organ transplants, maternity care, rehabilitative services, inpatient neonatal intensive care)	10% after deductible	30% after annual deductible plus \$500 copay per admission	10% after deductible	30% after annual deductible plus \$500 copay per admission
Hospital Visits (inpatient and outpatient)	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Outpatient Services				
Outpatient Surgery	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Outpatient Non-Surgical Care	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Outpatient Physical, Speech and Occupational Therapy Services (60 visits per calendar year, combined for all therapies)	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Outpatient Cardiac and Respiratory Therapy	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Outpatient Radiation and Chemotherapy	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Outpatient Dialysis	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Skilled Nursing, Home Health and Hospice Care Services				
Skilled Nursing Facility Care/Rehabilitation Center (120 days per calendar year)	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Home Health Care Services	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Hospice (210 day lifetime)	No Copay	30% after deductible	No Copay	30% after deductible
Emergency and Urgent Care Services				
Emergency Care at Hospital Emergency Room (waived if admitted)	\$100 Copay	\$100 Copay	\$200 Copay	\$200 Copay
Urgent Care Facility	\$15 Copay	30% after deductible	\$15 Copay	30% after deductible
Convenient Care Clinics	\$15 Copay	30% after deductible	\$15 Copay	30% after deductible
Ambulance services to hospital (emergency only)	10% after deductible	10% after deductible	10% after deductible	10% after deductible

Broward Sheriff's Office - 2011 PPO Medical Benefits and Alternative Plan Designs - Oct. 21, 2011 Alternate I

Plan Name	Current PPO 13342 -In Area (*) 13343 -Out-of-Area		Proposed Alternative PPO 13342-1a - In Area (*) 13343-2a - Out-of-Area	
Employee Contribution	\$64.75 Single/\$189.00 Family		\$64.75 Single/\$189.00 Family	
ID Card Description	BSO LG PPO 2011 / BSO LG PPO OOA 11		BSO PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health Services				
Inpatient Treatment	10% after deductible	30% after deductible plus \$500 copay per admission	10% after deductible	30% after deductible plus \$500 copay per admission
Outpatient Treatment	\$15 Copay	30% after deductible	\$15 Copay	30% after deductible
Substance Abuse Services				
Inpatient Detoxification & Rehabilitation	10% after deductible	30% after deductible plus \$500 copay per admission	10% after deductible	30% after deductible plus \$500 copay per admission
Outpatient Rehabilitation Treatment	\$15 Copay	30% after deductible	\$15 Copay	30% after deductible
Family Planning Services				
Infertility Services	Not Covered		Not Covered	
Medically Necessary/Elective Abortion	Elective-Not Covered		Elective-Not Covered	
Elective Sterilization	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Intrauterine Devices (IUD) (device, insertion, removal)	\$15 Copay	30% after deductible	\$15 Copay	30% after deductible
Other Covered Services				
Durable Medical Equipment	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Breast Prosthetic and other External Orthotics/Prosthetics	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Hearing Aids (other than cochlear implants)	Not Covered		Not Covered	
Insulin	Applicable RX copay	30% after deductible	Applicable RX copay	30% after deductible
Diabetic Supplies (includes glucose monitors, test strips, lancets, etc)	No Copay	30% after deductible	No Copay	30% after deductible
Prescription Drug Coverage 30-day supply (1)	Tier 1 - \$10; MO: \$10 Tier 2 - \$20; MO: \$20 Tier 3 - \$35; MO: \$35	30% after deductible	Tier 1 - \$10; MO: \$20 Tier 2 - \$25 MO: \$50 Tier 3 - \$50; MO: \$100 Tier 4 - 20% to a maximum of \$250 per month out-of-pocket; MO: not applicable	30% after deductible
Mail Order (MO) 90-day supply)				
Self-Injectables	Applicable RX copay; MO not applicable	30% after deductible; MO not applicable	Applicable RX copay; MO not applicable	30% after deductible; MO not applicable

(*) Active employees and retirees residing in the State of Florida, but outside the Coventry HMO/POS service area are eligible to enroll in this plan. The HMO service area includes the following counties: Miami-Dade, Broward, Palm Beach, Martin, St. Lucie, Hendry, Escambia, Santa Rosa, Calhoun, Liberty, Franklin, Gadsden, Leon, Wakula, Jefferson, Madison, Lafayette, Suwannee, Hamilton, Gilchrist, Union, Bradford, Alachua, Levy and Marion County.

(1) If a brand name medication is requested when a generic is available, you must pay 100% of the difference in price between the generic and brand name medication, plus the applicable brand copayment. Insulin & Diabetic supplies are covered as part of the prescription drug benefit. Prescription drug copayments do not apply toward the out-of-pocket maximum.
 Certain Covered Services require Prior Authorization. If you do not obtain authorization for service which require a Prior Authorization, the benefit otherwise payable by Coventry is reduced by 20%. This additional out-of-pocket amount will not be used to satisfy Deductible, Coinsurance or Out-of-Pocket Maximum requirements. Please refer to the Certificate of Insurance for further details on Prior Authorization requirements.

All Out-of-Network services are subject to the Out-of-Network Deductible, except for preventive care services and emergency room services, and applicable Coinsurance. In addition to the applicable Deductible and Coinsurance, Covered Persons who receive services from Non-Participating Providers shall be responsible for the difference between the Non-Participating Provider's bill and the Out-of-Network Rate.