

BENEFITS SUMMARY - AFSCME (THIRD CIRCUIT COURT)

AFSCME Locals 1905 & 3309

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.*

Medical and Prescription Drug Plan Benefits

Benefit Description	Community Blue PPO	Blue Cross Traditional	Health Alliance Plan (HAP) HMO
Plan Type	PPO	Traditional Indemnity	HMO
Groups Numbers	29203-660	29203-000	1-96180-AF
Employee Monthly Contributions Towards Health Plan Enrollment (for the period 10/1/2011 through 9/30/2012)			
Single person coverage	\$123.80	\$307.90	\$123.80
Two person coverage	<i>Employees whose annual rate is under \$31,200 will contribute 1/2 of this rate</i>	<i>Employees whose annual rate is under \$31,200 will contribute 1/2 of this rate</i>	<i>Employees whose annual rate is under \$31,200 will contribute 1/2 of this rate</i>
Family coverage			
Services in the Hospital			
Number of days of care	Covered 90% after deductible	Covered 100% up to 365 days, 60 day renewal; additional days under Master Medical at 100%.	Unlimited
Semi-private room and intensive care	Covered 90% after deductible	Covered	Covered
Miscellaneous services	Covered 90% after deductible	Covered	Covered
Surgery and all related surgical services	Covered 90% after deductible	Covered	Covered
Anesthesia	Covered 90% after deductible	Covered	Covered
Laboratory tests and x-rays	Covered 90% after deductible	Covered	Covered
Physical Therapy	Covered 90% after deductible	Covered	Covered
Medicines and drugs	Covered 90% after deductible	Covered	Covered
Human Organ Transplant	Covered 90% after deductible according to plan guidelines except experimental; in designated facilities only for heart, heart/lung, lung, pancreas, and liver transplant.	Covered 100% according to plan guidelines except experimental; in designated facilities only for heart, heart/lung, lung, pancreas, and liver transplant.	Covered according to plan guidelines (excluding experimental / investigational).

Medical and Prescription Drug Plan Benefits

Benefit Description	Community Blue PPO	Blue Cross Traditional	Health Alliance Plan (HAP) HMO
Emergency Care (Medical and Accidental)			
Hospital and physician services	Covered with \$50 copay (waived if admitted or for accidental injury)	Covered	Covered with \$50 copay (waived if admitted)
Urgent care facility	Covered in-network only with \$20 copay; Covered out-of-network 90% after deductible only if medically necessary	Covered	Covered with \$20 copay
Ambulance	Covered 90% after deductible	Covered under Master Medical	Covered
Physician Services			
Routine / periodic physical exam	Covered 100% once per calendar year	Not Covered	Covered with \$20 copay
Office visits with medical diagnosis	Covered in-network only with \$20 copay; Covered out-of-network 70% after deductible only if medically necessary	Covered with diagnosis under Master Medical (excludes well-baby care)	Covered with \$20 copay
Consulting specialist care	Covered in-network only with \$20 copay; Covered out-of-network 70% after deductible only if medically necessary	Covered under Master Medical with diagnosis	Covered with \$20 copay
Maternity Services Provided by a Physician			
Outpatient pre-natal and post-natal care	In-Network: Covered 100%; Out-of-Network: Covered 70% after deductible	Covered	Covered with \$20 copay
Delivery in hospital	Covered after deductible and copay	Covered	Covered
Newborn baby care in hospital	Covered 90% after deductible	Covered	Covered
Prescription Drugs			
Generic drug	Covered with \$5 copay		
Brand-name drug	Covered with \$25 copay		
Mail-order drug	90-day supply covered at 2 x copay		
Annual copay dollar maximums (out-of-pocket maximums)	\$1,500 per member / \$3,000 per family per year or benefit period		
Other Features	~ Mandatory generic ~ Step Therapy ~ 90-day retail program		
Diagnostic and Therapeutic Procedures			
Laboratory tests	Covered after deductible and copay unless part of a preventative visit, then covered at 100%	Covered with diagnosis	Covered
Radiation therapy	Covered after deductible and copay	Covered	Covered
Physical, speech & occupational Therapy	Covered after deductible and copay combined 60-day maximum per calendar year	Covered 100% within 1st 60 calendar days; renewable annually; additional days under Master Medical	Covered up to 60 combined visits per benefit period
Diagnostic radiology	Covered after deductible and copay unless part of a preventative visit, then covered at 100%	Covered with diagnosis	Covered

Medical and Prescription Drug Plan Benefits

Benefit Description	Community Blue PPO	Blue Cross Traditional	Health Alliance Plan (HAP) HMO
Preventative Services			
Routine / Preventative Physical Exam	Covered 100% once per calendar year	Not covered	Covered with \$20 copay
Well-baby care visits	Covered 100%: ~ 6 visits, birth through 12 months ~ 6 visits, 13 mos. through 23 mos. ~ 2 visits, 24 mos. through 35 mos. ~ 2 visits, 36 mos. through 47 mos.	Not covered	Covered with \$20 copay
Immunizations	Covered 100% through age 16	Not covered	Covered
Voluntary Sterilization	Covered 90% after deductible	Covered	Covered
IUDs and other contraceptive devices	Covered 90% after deductible	Covered	Covered
Mammography screening	Covered 100% once per calendar year	Covered once between the ages of 35 to 40; annually after age 40	Covered
Pap Smear	Covered 100% once per calendar year	Covered once annually	Covered
Fecal Occult Blood Screening	Covered 100% once per calendar year	Not covered	Covered
Flexible sigmoidoscopy exam	Covered 100% once per calendar year	Not covered	Covered
Prostate specific antigen (PSA) screening	Covered 100% once per calendar year	Not covered	Covered
Mental Health Care Services			
Outpatient psychiatric services	Covered 50% after deductible	Covered up to \$400 per member per year subject to copays; additional visits under Master Medical	Covered with \$20 copay
Inpatient psychiatric services	Covered 50% after deductible	Covered up to 45 days; renewable after 60 days; additional days under Master Medical	Covered
Substance Abuse Treatment			
Outpatient substance abuse treatment	Covered 50% after deductible in approved facilities up to state-dollar amount which is adjusted annually	Covered 100% up annually adjusted state-mandated dollar amount in an approved outpatient facility program	Covered with \$20 copay
Inpatient substance abuse treatment	Covered 50% after deductible in approved facilities	Covered up to 100% of unused mental health care days in an approved hospital residential program	Covered
Alternative to Hospital Care			
Skilled nursing facility	Covered 90% after deductible and copay up to 120 days per calendar year	Covered up to 730 days; renewable after 60 days	Covered up to 730 days; renewable after 60 days
Home health care services	Covered	Covered	Covered
Custodial care facility	Not covered	Not covered	Not covered
Hospice care facility	Covered up to lifetime dollar max. which is adjusted periodically	Covered up to annual maximums set by law at approved facilities	Covered up to 210 days per lifetime
Chiropractic Services			
	Covered 100% up to 24 visits per year	Covered under Master Medical	Not Covered

Medical and Prescription Drug Plan Benefits

Benefit Description	Community Blue PPO	Blue Cross Traditional	Health Alliance Plan (HAP) HMO
Appliances and Prosthetic Devices	Covered 90% after deductible	Covered under Master Medical	Covered
Durable Medical Equipment	Covered 90% after deductible	Covered under Master Medical	Covered
Vision Services (See also <i>Vision Plan Benefits</i> section of this Guide for additional coverage information)			
Eye examination	Covered only with medical diagnosis unless enrolled in Heritage Vision Plan, then covered once every 2 years with \$10 copay	Covered only with medical diagnosis	Covered with \$10 copay for routine eye exam, \$20 copay for all other vision services
Corrective lenses	Not covered	Not covered	Not covered
Eyeglass frames	Not covered	Not covered	Not covered
Hearing Services (See also <i>Hearing Plan Benefits</i> section of this Guide for additional voluntary benefit coverage information)			
Hearing screening	Not covered	Not covered	Covered with \$20 copay
Hearing examination	Covered with medical diagnosis only	Covered with medical diagnosis only	Covered with \$20 copay
Hearing aids	Not covered	Not covered	Not covered
Deductibles, Copays, Benefit and Out-of-Pocket Maximums			
In-network annual deductible	\$100 per member / \$200 per family per year	\$50 per person per year; no more than \$100 per family per year for Master Medical services	None
Out-of-network annual deductible	\$250 per member / \$500 per family per year		No out-of-network coverage except for emergency
In-network copays	Unless otherwise specified, 10% for general services; 50% for mental health, substance abuse treatment and private-duty nursing services	20% for general services under Master Medical; 50% for mental health and private-duty nursing services	\$20 for office visit / urgent care; \$50 for emergency room visit (unless admitted / accidental injury); \$10 routine eye exam & \$20 all other vision services
Out-of-network copays	30% unless otherwise specified		No out-of-network coverage except for emergency
In-network annual copay dollar maximums (out-of-pocket maximums)	\$500 per member / \$1,000 per family per year (excluding office visit & emergency room copays, as well as copays for mental health, substance abuse and private-duty nursing services)	\$1,000 per family per year for general services under Master Medical (excluding mental health, substance abuse and private-duty nursing services)	None
Out-of-network annual copay dollar maximums (out-of-pocket maximums)	\$1,500 per member / \$3,000 per family per year (excluding mental health, substance abuse and private-duty nursing services)		None
Claim forms necessary	No	Master Medical claims only	No
Worldwide Reimbursement	Yes, except for preventative services	Yes	Yes, for emergency / urgent care
Insurance Company Contact Information			
Insurance Carrier	Blue Cross Blue Shield of MI	Blue Cross Blue Shield of MI	Health Alliance Plan (HAP)
Customer Service Number	(800) 921-5504	(800) 921-5504	(800) 422-4641
Address	600 E. Lafayette Detroit, MI 48226	600 E. Lafayette Detroit, MI 48226	2850 W. Grand Blvd Detroit, MI 48202
Web Site	www.bcbsm.com	www.bcbsm.com	www.hap.org

Opting Out of Medical and Prescription Drug Coverage

Employees may elect to opt out of medical and prescription drug coverage and receive an annual cash rebate as specified under the terms and conditions of your CBA or benefit plan. Employees wishing to do so must complete the proper Reduction in Health Care Opt Out Form and provide proof of other group health care coverage. Employees covered as spouses under another Wayne County employee policy are not eligible for participation in the opt out program.

Earnings are calculated based on 15% of the average PPO and HMO premium for the coverage tier (single, two-person or family) for which you would have qualified. Proof of dependent eligibility will be required in order to determine the appropriate coverage tier.

Plan Year	Single Person	Two Person	Family
2011-12 Opt Out Earnings	\$812.43	\$1,908.30	\$2,229.70

BENEFITS SUMMARY - HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

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.

HDHP Medical and Prescription Drug Plan Benefits

Benefit Description	BCBSM Flexible Blue
Plan Type	HDHP / PPO
Groups Numbers	81124-701
Employee Monthly Contributions Towards Health Plan Enrollment (for the period 10/1/2011 through 9/30/2012)	
Single person coverage	No employee contribution required
Two person coverage	
Family coverage	
NOTE: Services without a PPO network and emergency services are covered at the in-network level. However, unlike the Community Blue and Blue Preferred PPO plans, if a PPO provider refers you to a non-network provider, all covered services obtained from that non-network provider will be subject to applicable out-of-network cost-sharing. If you receive care from a non-participating provider under this plan, even when referred, you may be billed for the difference between our approved amount and the provider's charges.	
Services in the Hospital	
Number of days of care	Unlimited days
Semi-private room and intensive care	Covered 90% after in-network deductible
Surgery and all related surgical services	Covered 90% after in-network deductible
Anesthesia	Covered 90% after in-network deductible
Laboratory tests and x-rays	Covered 90% after in-network deductible
Physical Therapy	Covered 90% after in-network deductible
Medicines and drugs	Covered 90% after in-network deductible
Miscellaneous services	Covered 90% after in-network deductible
Human Organ Transplants	
Specified human organ transplant	Covered 100% after in-network deductible in designated facilities only according to plan guidelines except experimental. \$1 million lifetime per member maximum per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services. Must be coordinated through the BCBSM Human Organ Transplant Program.
Bone marrow transplant	Covered 90% after in-network deductible when coordinated through the BCBSM Human Organ Transplant Program
Specified oncology clinical trials	Covered 90% after in-network deductible
Kidney, cornea and skin	Covered 90% after in-network deductible
Emergency Care (Medical and Accidental)	
Hospital and physician services	Covered 90% after in-network deductible
Urgent care facility	Covered 90% after in-network deductible
Ambulance	Covered 90% after in-network deductible
Physician Services	
Routine / periodic physical exam	Covered 100% once per calendar year not subject to deductible or copays
Office visits with medical diagnosis	Covered 90% after in-network deductible
Consulting specialist care	Covered 90% after in-network deductible
Maternity Services Provided by a Physician	
Outpatient pre-natal and post-natal care	Covered 90% after in-network deductible
Delivery in hospital	Covered 90% after in-network deductible
Newborn baby care in hospital	Covered 90% after in-network deductible
Prescription Drugs	
Preventive Drugs <i>(based on BCBSM Standard Preventive Drug List - contact Benefit Administration for list)</i>	Covered 100% for qualified drugs up to \$500 per member annually not subject to deductibles or prescription drug copays.

HDHP Medical and Prescription Drug Plan Benefits

Benefit Description	BCBSM Flexible Blue
Generic Drug	Covered with \$5 copay subject to deductible; includes contraceptives
Brand-Name Drug	Covered with \$25 copay subject to deductible; includes contraceptives
Mail-Order	90-day supply covered at 2 x copay subject to deductible
Other Features	Mandatory generic Step Therapy 90-day Retail Program
Diagnostic and Therapeutic Procedures	
Laboratory tests	Covered 90% after in-network deductible
Diagnostic x-rays	Covered 90% after in-network deductible
Physical, speech & occupational Therapy	Covered 90% after in-network deductible - limited to a combined maximum of 60 visits per member per calendar year
Radiation therapy	Covered 90% after in-network deductible
Allergy testing and therapy	Covered 90% after in-network deductible
Preventative Services	
Routine / Preventative Physical Exam	Covered 100% once per calendar year - not subject to deductible or copays
Well-baby care visits	Covered 100% not subject to deductible or copays ~ 6 visits, birth through 12 months ~ 6 visits, 13 mos. through 23 mos. ~ 2 visits, 24 mos. through 35 mos. ~ 2 visits, 36 mos. through 47 mos.
Immunizations	Covered 100% through age 15
Voluntary Sterilization	Covered after deductible and copay
IUDs and other contraceptive devices	Covered after deductible and copay
Mammography screening	Covered 100% once per calendar year - not subject to deductible or copays
Pap Smear	Covered 100% once per calendar year - not subject to deductible or copays
Fecal Occult Blood Screening	Covered 100% once per calendar year - not subject to deductible or copays
Flexible sigmoidoscopy exam	Covered 100% once per calendar year - not subject to deductible or copays
Prostate specific antigen (PSA) screening	Covered 100% once per calendar year - not subject to deductible or copays
Mental Health Care and Substance Abuse Treatment Services	
Inpatient mental health and inpatient substance abuse treatment	Covered 90% after in-network deductible - limited to a combined maximum of 60 days per calendar year with 120 days lifetime per member
Outpatient mental health care	Covered 90% after in-network deductible
Outpatient substance abuse treatment	Covered 90% after in-network deductible - limited to annual state-dollar amount (that combines outpatient and residential substance abuse)
Alternative to Hospital Care	
Skilled nursing facility	Covered 100% after in-network deductible in participating skilled nursing facilities only - limited to 90 days per calendar year
Home health care services	Covered 100% after in-network deductible by a participating home health care agency only
Hospice care facility	Covered 100% after in-network deductible in participating hospice program only - limited to dollar maximum that is reviewed and adjusted periodically
Home infusion therapy when medically necessary	Covered 100% after in-network deductible by participating providers only
Custodial care facility	Not covered
Chiropractic Services	Covered 90% after in-network deductible - up to 24 visits per member per calendar year
Prosthetic and orthotic appliances	Covered 90% after in-network deductible
Durable Medical Equipment	Covered 90% after in-network deductible
Vision Services (see Vision Benefits Plan section for additional coverage information)	
Eye examination	Covered only with medical diagnosis unless enrolled in Heritage Vision Plan, then covered once every 2 years with \$10 copay
Corrective lenses	Not covered
Eyeglass frames	Not covered

HDHP Medical and Prescription Drug Plan Benefits

Benefit Description	BCBSM Flexible Blue
Hearing Services (see Hearing Benefits Plan section for voluntary plan coverage information)	Covered only with medical diagnosis as an office visit
Deductibles, Copays, Benefit and Out-of-Pocket Maximums	
Annual deductible (deductibles are based on amounts defined annually by the federal government for HDHPs)	In-network: \$1,250 for a single-person contract or \$2,500 for a family contract (2 or more members) each calendar year; Out-of-network: \$2,500 for a single person contract or \$5,000 for a family contract each calendar year NOTE: the full-family deductible <u>must</u> be met under a two-person or family contract before any benefits are paid for any person on the contract; no 4th quarter carry over for either in-network or out-of-network deductible
Copays	In-network: 10% unless otherwise specified; Out-of-network: 30% unless otherwise specified
Annual copay dollar maximums (combined out-of-pocket maximums for medical and prescription drug copays)	In-network: \$1,000 for a single-person contract or \$2,000 for a family contract (2 or more members) each calendar year; Out-of-network: \$2,000 for a single person contract or \$4,000 for a family contract each calendar year NOTES: the full-family annual copay dollar maximum <u>must</u> be met under a two-person or family contract before copays no longer apply
Claim forms necessary	No
Worldwide Reimbursement	Yes, except for office visits
Insurance Company Contact Information	
Insurance Carrier	Blue Cross Blue Shield of MI
Customer Service Number	(800) 921-5504
Address	600 E. Lafayette Detroit, MI 48226
Web Site	www.bcbsm.com

MAXIMIZE YOUR HEALTHCARE DOLLARS!

Use a Health Savings Account (HSA) to maximize your savings on healthcare expenditures.

Employees electing to enroll in the the high-deductible health plan (HDHP) are eligible to set funds aside tax free in an HSA and withdraw those funds tax free to pay for qualified medical expenses incurred for themselves and their eligible dependents.

To learn more about this money-saving program, see page 23 of this Guide.

BENEFITS SUMMARY - AFSCME (THIRD CIRCUIT COURT)

AFSCME Locals 1905 & 3309

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	Blue Cross Traditional Plus Dental	Golden Dental Plan
Plan Type	Traditional Indemnity	DMO
Groups Numbers	29203-000, -660	GDP
Employee Monthly Contributions Towards Health Plan Enrollment (for the period 10/1/2011 through 9/30/2012)		
Single person coverage	None	None
Two person coverage		
Family coverage		
Diagnostic and Preventative Services		
Exams, x-rays, cleanings and flouride treatment	Covered	Covered
Restorative Services		
Fillings, crowns and repairs / relines to existing prosthetic appliances	Covered	Covered
Oral Surgery		
Extractions and surgery performed by a dentist	Covered	Covered
When performed by a specialist	Covered with 15% copay	Covered with 15% copay
Endodontic Services		
Root canals and treatment of damaged nerves	Covered with 15% copay	Covered with 15% copay
Prosthetic Care		
Construction of dentures and bridges	Covered with 15% copay	Covered with 15% copay
Periodontic Services		
Gum treatment and appliances	Covered with 15% copay	Covered with 15% copay
Orthodontic Services		
Correction of malposed teeth	Covered at 50% to a <u>lifetime</u> maximum of \$1,000 with no age restrictions	Two-year banding program covered at 100% through age 18; age 19 and over covered with \$1,250 deductible.
Annual Benefit Maximum	\$1,000 per calendar year for all services except orthodontic. Lower costs by using BCBSM participating dentists. Further reduce costs by using DenteMax dentists.	None
Insurance Company Contact Information		
Insurance Carrier	Blue Cross Blue Shield of MI	Golden Dental Plans, Inc.
Customer Service Number	(800) 921-5504	(800) 451-5918
Address	600 E. Lafayette, Detroit, MI 48226	29377 Hoover Road, Warren, MI 48093
Web Site	www.bcbsm.com	www.goldendentalplans.com

BENEFITS SUMMARY - AFSCME (THIRD CIRCUIT COURT)

AFSCME Locals 1905 & 3309

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	Wayne County Optical Reimbursement Program	Heritage Vision Insurance Plan
Plan Type	Reimbursement Plan	HMO Plan
Groups Numbers	OPT175	HVP
Employee Monthly Contributions Towards Health Plan Enrollment (for the period 10/1/2011 through 9/30/2012)		
Single person coverage	None	None
Two person coverage		
Family coverage		
Vision exams	Covered	Covered under medical plan with \$10 copay
Eyeglasses		
Lenses	Covered when prescribed by a licensed optometrist, optician or ophthalmologist	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 when prescribed by a licensed optometrist, optician or ophthalmologist	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	Covered 100% in-network
Other lens upgrades: progressive lenses, thin lenses, anti-reflective coating, UV protection, scratch coating, etc.	Covered	20% in-network preferred pricing discount granted for all lens upgrades not covered by the plan
Contact Lenses		
Elective contacts	Covered	Covered in-network up to \$100 retail allowance; reimbursed up to \$65 out-of-network
Medically necessary	Covered	Covered 100% in-network with prior approval for medical necessity; reimbursed up to \$200 out-of-network with prior approval
Maximum Benefit	\$175 reimbursement per person per 2-year policy period	Member eligible for glasses or contact lenses (not both) in any 24-month consecutive period
Policy Period	Renews October 1st of every odd year; minimum 2-year plan enrollment required	Minimum 2-year plan enrollment required
Plan Administration Contact Information		
Plan Administrator	Wayne County Benefits Administration Division	Heritage Vision Plans
Customer Service Number	(313) 224-7721	(888) 322-0919
Address	500 Griswold, Ste 900, Detroit, MI 48226	440 E. Congress, Ste 300, Detroit, MI 48226
Web Site	www.waynecounty.com	www.heritagevisionplans.com

BENEFITS SUMMARY - ALL EMPLOYEES

The following chart describes the essential features of the plan in general terms. The summary describes services provided only through approved hearing aid centers / vendors. It is not intended to be a full description of services. You will receive a copy of the plan description and ID cards directly from each company through a direct mailing to your home.

Supplemental Hearing Care / Aid Plan Benefits

Benefit Description	The Hearing Center for Excellence	Epic Hearing
Plan Type	Group Discount Plan available to employees, retirees, and their dependents	Group Discount Plan available to employees, retirees, and their dependents
Groups Numbers	N/A	N/A
Monthly Cost to Retiree	None	None
Annual Hearing Evaluation	Covered	Discounted if not covered under medical plan
Hearing Aid	\$750 (normally \$1,200) for entry level digital hearing aid. Upgraded mid-level and premium products similarly discounted around 25% of THCE's regular selling price.	Negotiated pricing as much as 50% below manufacturer's suggested retail price. Members have access to all makes, models and manufacturers. Members receive a published, preset hearing aid price list upon enrollment.
Services Covered with Purchase of a Hearing Aid		
Audiogram	\$20 cost (normally \$75)	Covered
Hearing aid evaluation	\$25 cost (normally \$130)	Covered
Hearing aid check	Covered quarterly	Covered
Hearing aid service	6 months for programming	Covered
Hearing aid batteries	One year supply covered	One year supply covered
Other Services (discount)	Swim Plugs, Musician Plugs, Hearing Aid Cleaning Supplies, TV Amplification, Hearing Aid Compatible Cell Phones, Assistive/Alerting Devices. Priority Appts. Onsite ear, nose & throat medical care. National & International retailers.	Swim Plugs, Musician Plugs, Hearing Aid Cleaning Supplies, TV Amplification, Hearing Aid Compatible Cell Phones, Assistive/Alerting Devices
Trial Period	90-day trial / adjustment period	45-day trial period
Warranty	1 or 2 years, depending on manufacturer	3 years
Provider Network	2 locations in southeast Michigan (in Dearborn and Livonia)	Nat'l network of credentialed ENT physicians and audiologists. Does not include hearing aid dispensers or hearing instrument specialists.
Plan Administration Contact Information		
Plan Administrator	The Hearing Center for Excellence	Epic Hearing
Customer Service Number	(877) 443-2748	(866) 956-5400
Address	15212 Michigan Ave Dearborn, MI 48126 and 14555 Levan Road, Suite 303 Livonia, MI 48154	17870 Castleton St, Suite 308 City of Industry CA 91742
Web Site	www.hearingexcellence.com	www.epichearing.com

LIFE INSURANCE BENEFITS – AFSCME Locals 1905 & 3309 (Third Circuit Court)

Information about your employer-paid basic life insurance plan

Your basic life insurance benefit is provided through the Mutual of Omaha policy.

Your employer-paid basic life insurance benefit is two times salary up to \$300,000 with additional benefits in the amount of \$100,000 if death occurs in the line of duty.

This policy converts to 25% of face value upon normal retirement not to exceed \$50,000.

Supplemental life insurance benefits may be available during the Courts annual open enrollment period held annually in the fall.

For information about your life insurance benefit and whether your policy, or for beneficiary information / changes, please contact the Wayne County Third Circuit Court Personnel Office at (313) 224-7018.