

BENEFITS SUMMARY - UAW JUDICIAL ATTORNEYS ASSOCIATION (THIRD CIRCUIT COURT)

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 (In-Network Benefits)	Blue Cross Traditional (NOT OPEN FOR NEW ENROLLMENT)	Health Alliance Plan (HAP) (NOT OPEN FOR EMPLOYEES HIRED OR REHIRED ON OR AFTER 04/01/2006)
Plan Type	PPO	Traditional Indemnity	HMO
Groups Numbers	29203-615	29203-015	1-96180-AD
Monthly Employee Contributions Toward Health Plan Enrollment			
Single person coverage	\$ 30.61	\$ 27.38	\$ 41.84
Two person coverage	\$ 73.49	\$ 65.74	\$ 96.25
Family coverage	\$ 91.85	\$ 96.25	\$ 108.80
Services in the Hospital			
Number of days of care	Covered 100% at participating hospitals	Covered 100% up to 365 days, 60 day renewal; additional days under Master Medical at 100%.	Unlimited
Semi-private room and intensive care	Covered	Covered	Covered
Miscellaneous services	Covered	Covered	Covered
Surgery and all related surgical services	Covered	Covered	Covered
Anesthesia	Covered	Covered	Covered
Laboratory tests and x-rays	Covered	Covered	Covered
Physical Therapy	Covered up to 60 visits per calendar year	Covered	Covered
Medicines and drugs	Covered	Covered	Covered
Human Organ Transplant	Covered according to plan guidelines except experimental. Skin, cornea, kidney and bone marrow 100%. \$1 million lifetime maximum per transplant type in designated facilities for heart, heart/lung, lung, pancreas, and liver transplant.	Covered according to plan guidelines except experimental. Skin, cornea, kidney and bone marrow 100%. \$1 million lifetime maximum per transplant type in designated facilities for heart, heart/lung, lung, pancreas, and liver transplant.	Covered according to plan guidelines (excluding experimental / investigational).
Emergency Care (Medical and Accidental)			
Hospital and physician services	Covered	Covered	Covered
Urgent care facility	Covered with \$10 copay	Covered	Covered
Ambulance	Covered	Covered under Master Medical	Covered
Physician Services			
Office Visits	Covered with \$10 copay	Covered with diagnosis under Master Medical (excludes well-baby care)	Covered
Well-baby care visits	Covered with \$10 copay	Not covered	Covered
Consulting specialist care	Covered with \$10 copay	Covered under Master Medical with diagnosis	Covered

Medical and Prescription Drug Plan Benefits

Benefit Description	Community Blue PPO (In-Network Benefits)	Blue Cross Traditional (NOT OPEN FOR NEW ENROLLMENT)	Health Alliance Plan (HAP) (NOT OPEN FOR EMPLOYEES HIRED OR REHIRED ON OR AFTER 04/01/2006)
Routine / periodic physical exam	Covered once per calendar year with \$10 copay	Not Covered	Covered
Maternity Services Provided by a Physician			
Outpatient pre-natal and post-natal care	Covered with \$10 copay	Covered	Covered
Delivery in hospital	Covered	Covered	Covered
Newborn baby care in hospital	Covered	Covered	Covered
Prescription Drugs	Covered with \$5 copay; includes injectable insulin, needles, syringes and contraceptives; no mail order	Covered with \$5 copay; includes injectable insulin, needles, syringes and contraceptives; no mail order	Covered with \$5 copay; includes injectable insulin, needles, syringes, contraceptives and smoking cessation medication; mail order available
Diagnostic and Therapeutic Procedures			
Laboratory tests	Covered	Covered with diagnosis	Covered
Radiation therapy	Covered	Covered	Covered
Physical, speech & occupational Therapy	Covered up to 60 visits 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 x-rays	Covered with diagnosis	Covered with diagnosis	Covered
Preventative Services			
Immunizations	Covered up to age 16	Not covered	Covered
Voluntary family planning	Not covered	Not covered	Covered
Sterilization	Covered	Covered	Covered
IUDs and other contraceptive devices	Covered	Covered	Covered
Infertility counseling and treatment	Not covered	Not covered	Covered
Nutritional education and counseling	Not covered	Not covered	Covered
Health education counseling	Not covered	Not covered	Covered
Mammography screening	Covered once per calendar year	Covered once between the ages of 35 to 40; annually after age 40	Covered
Pap Smear	Covered once per calendar year	Covered once annually	Covered
Mental Health Care Services			
Outpatient psychiatric services	Covered with 50% copay	Covered up to \$400 per member per year subject to copays; additional visits under Master Medical	Covered
Inpatient psychiatric services	Covered with 50% copay	Covered up to 45 days; renewable after 60 days; additional days under Master Medical	Covered

Medical and Prescription Drug Plan Benefits

Benefit Description	Community Blue PPO (In-Network Benefits)	Blue Cross Traditional (NOT OPEN FOR NEW ENROLLMENT)	Health Alliance Plan (HAP) (NOT OPEN FOR EMPLOYEES HIRED OR REHIRED ON OR AFTER 04/01/2006)
Substance Abuse Treatment			
Outpatient substance abuse treatment	Covered with 50% copay up to annually adjusted state-mandated dollar amount in an approved outpatient facility program	Covered 100% up to annually adjusted state-mandated dollar amount in an approved outpatient facility program	Covered
Inpatient substance abuse treatment	Covered with 50% copay in approved facilities; unlimited days	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	Covered up to 730 days; renewable after 60 days	Covered up to 730 days; renewable after 60 days
In-home nursing services	Covered	Covered under Master Medical	Covered
Home health care services	Covered	Covered	Covered
Custodial care facility	Not covered	Not covered	Not covered
Hospice care facility	Covered up to annual maximums set by law at approved facilities	Covered up to annual maximums set by law at approved facilities	Covered up to 210 days per lifetime
Individual case management	Covered	Covered	Covered
Private-duty nursing	Covered with 50% copay	Covered under Master Medical	
Chiropractic Services	Covered 100% up to 24 visits per calendar year	Covered under Master Medical	Not Covered
Appliances and Prosthetic Devices			
When medically necessary	Covered	Covered under Master Medical	Covered for authorized equipment
When body's growth or development necessitates replacement	Covered	Covered under Master Medical	Covered according to plan guidelines
Normal wear	Covered	Covered under Master Medical	Covered according to plan guidelines
Durable Medical Equipment	Covered	Covered under Master Medical	Covered for authorized equipment
Vision Services (See Vision Benefits Section of this Guide for additional coverage information)			
Vision screening	Covered once annually with \$10 copay or with medical diagnosis	Covered with medical diagnosis only	Covered
Eye examination	Covered once annually with \$10 copay or with medical diagnosis	Covered with medical diagnosis only	Covered
Corrective lenses	Covered once annually with \$10 copay	Not Covered	Not Covered
Eyeglass frames	Covered once annually with \$10 copay	Not Covered	Not Covered
Hearing Services			
Hearing screening	Covered with medical diagnosis only	Covered with medical diagnosis only	Covered
Hearing examination	Covered with medical diagnosis only	Covered with medical diagnosis only	Covered
Hearing aids	Not covered	Not covered	Covered (<i>conventional aids only</i>)

Medical and Prescription Drug Plan Benefits

Benefit Description	<u>Community Blue PPO</u> (In-Network Benefits)	<u>Blue Cross Traditional</u> (NOT OPEN FOR NEW ENROLLMENT)	<u>Health Alliance Plan (HAP)</u> (NOT OPEN FOR EMPLOYEES HIRED OR REHIRED ON OR AFTER 04/01/2006)
Deductibles and Copays			
Annual deductible	None	\$50 per person per year; no more than \$100 per family per year for Master Medical services	None
Copays	Covered as specified for each service listed above	20% for general services and 50% for mental health and private-duty nursing services provided under Master Medical	None
Annual Out-of-Pocket Maximums	None	\$1,000 for copays paid on general services provided under Master Medical	None
Claim forms necessary	No	Master Medical claims only	No
Worldwide Reimbursement	Yes	Yes	Yes, for emergency / urgent care
Member Coverage			
In-network	Covered as specified for each service listed above	Yes	Yes
Out-of-network	Covered up to approved amounts with 20% copay	Yes, up to approved amounts	Emergency services only
Children age 19 to 25 years of age	Covered if child meets definition of dependent as defined by IRS; \$30 per month payroll deduction will apply if child is not a full-time student		
Disabled children	Covered under the provisions of Public Act 275		
Sponsored dependents	May be covered if dependent eligibility rules apply; payment of premium required		
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.

Opt out earnings are a flat \$950 payment paid on a bi-weekly basis. Opt out payments are considered taxable income and will be classified that way on the paycheck in which you receive the payment.

Plan Year	Single Person	Two Person	Family
2011-12 Bi-Weekly Opt Out Earnings	\$36.54	\$36.54	\$36.54

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Dental Plan Benefits

Benefit Description	Blue Cross Dental (Employees Enrolled in Community Blue PPO Plan)	Blue Cross Dental (Employees NOT Enrolled in Community Blue PPO Plan)	Golden Dental Plan (NOT OPEN TO EMPLOYEES ENROLLED IN COMMUNITY BLUE PPO)
Plan Type	Traditional Indemnity	Traditional Indemnity	DHMO
Groups Numbers	29203-615	29203-015	GDP
Monthly Employee Contribution Toward Health Plan Enrollment			
Single Person	None	None	\$0.89
Two Person	None	None	\$1.37
Family	None	None	\$2.30
Diagnostic and Preventative Services			
Examinations, x-rays, cleanings and fluoride treatment	Covered	Covered	Covered
Restorative Services			
Fillings, crowns and repairs / relines to existing prosthetic appliances	Covered with 10% copay	Covered	Covered
Oral Surgery			
Extractions and surgery performed by a dentist	Covered with 10% copay	Covered	Covered
When performed by a specialist	Covered with 10% copay	Covered with 15% copay	Covered with 15% copay
Endodontic Services			
Root canals and treatment of damaged nerves	Covered with 10% copay	Covered with 15% copay	Covered with 15% copay
Prosthetic Care			
Construction of dentures and bridges	Covered with 50% copay	Covered with 15% copay	Covered with 15% copay
Periodontic Services			
Gum treatment and appliances	Covered with 10% copay	Covered with 15% copay	Covered with 15% copay
Orthodontic Services			
Correction of malposed teeth	Covered at 50% to a lifetime maximum of \$2,000 for members through age 19	Covered at 50% to a lifetime maximum of \$500 for members with no age restrictions	2-year banding program covered at 100% through age 18; age 19 and over covered with \$1,250 deductible.
Annual Benefit Maximum	\$2,000 per calendar year for all services except orthodontic	\$1,000 per calendar year for all services except orthodontic	None
Insurance Company Contact Information			
Insurance Carrier	Blue Cross Blue Shield of MI	Blue Cross Blue Shield of MI	Golden Dental Plans, Inc.
Customer Service Number	(800) 921-5504	(800) 921-5504	(800) 451-5918
Address	600 E. Lafayette Detroit, MI 48226	600 E. Lafayette Detroit, MI 48226	29377 Hoover Road Warren, MI 48093
Web Site	www.bcbsm.com	www.bcbsm.com	www.goldendentalplans.com

Benefit Description	Blue Cross Dental (Employees Enrolled in Community Blue PPO Plan)	Blue Cross Dental (Employees NOT Enrolled in Community Blue PPO Plan)	Golden Dental Plan (NOT OPEN TO EMPLOYEES ENROLLED IN COMMUNITY BLUE PPO)
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Vision Plan Benefits

Benefit Description	Blue Cross Vision (Employees Enrolled in Community Blue PPO Plan)	Wayne County Optical Reimbursement Program (Employees NOT Enrolled in Community Blue PPO Plan)
Plan Type	PPO Plan	Reimbursement Plan
Groups Numbers	29203-615	OPT175
Monthly Employee Contribution Toward Health Plan Enrollment		
Single Person	\$2.36	None
Two Person	\$5.04	None
Family	\$6.07	None
Vision Services		
Vision screening and exams	Covered once annually with \$10 copay	Covered
Corrective lenses	Covered once annually when prescribed by a licensed optometrist, optician or ophthalmologist with \$10 copay	Covered when prescribed by a licensed optometrist, optician or ophthalmologist
Eyeglass frames	Covered once annually when prescribed by a licensed optometrist, optician or ophthalmologist with (\$10 copay if no lenses purchased)	Covered when prescribed by a licensed optometrist, optician or ophthalmologist
Maximum Benefit	\$175 annual maximum benefit	\$175 per member during 2-year policy period for all services
Policy Period	Annual	Bi-annual; renews on December 1st of every odd year
Plan Administration Contact Information		
Plan Administrator	Blue Cross Blue Shield of MI	Wayne County Benefit Administration Division
Customer Service Number	(800) 921-5504	(313) 224-7721
Address	600 E. Lafayette Detroit, MI 48226	500 Griswold Street, Suite 900 Detroit, MI 48226
Web Site	www.bcbsm.com	www.waynecounty.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 – UAW Judicial Attorneys Association (JAA)

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 accidental death benefits of \$100,000 if death occurs in the line of duty.

This policy converts to 25% of face value upon normal retirement up to a maximum of \$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) 224-8816.