

INFORMATION REGARDING YOUR MEDICAL PLAN OPTIONS

Information to help you understand your plan choices.

You have a choice between three medical plans – a PPO, an HMO and a Traditional Indemnity plan. The information below should help you to better understand the general differences between these types of plans so that you can make an informed decision about which plan is best for your family in the upcoming plan year. The benefit summaries specific to your labor agreement provided on the pages following this section will give you more detailed information regarding what services are covered under each of these plans.

Traditional Indemnity Plan

A traditional indemnity plan is a fee for service, group health insurance plan, in which the patient may choose whichever physician or hospital he or she wishes to use. The traditional plans administered by Wayne County are provided through [Blue Cross Blue Shield of Michigan \(BCBSM\)](#). With a traditional plan, contracted hospitals and participating physicians will accept the negotiated usual, customary, and reasonable (UCR) fees as maximum payment for services. Non-participating physicians and hospitals may charge more than the UCR fees. The patient must pay the difference if he/she chooses to receive services from a non-participating provider. Preventative services are not usually covered under this type of plan.

Some services under the traditional plan are covered under Master Medical (MM). The patient pays an annual deductible and/or co-payments per medical visit for services covered under MM. MM is a reimbursement plan; therefore, the patient is responsible for paying the medical provider up front for these services and will be reimbursed under the plan upon submission of a MM claim to the insurance carrier.

Preferred Provider Organization (PPO)

A PPO is an organization of health care providers that contracts on a fee-for-service basis with an insurance company or self-funded employer to provide medical services at a discounted amount. Insurance plans, like [BCBSM Community Blue](#), are called PPOs because the benefits are either *In-Network* (health care obtained from a preferred list of providers) or *Out-of-Network* (health care obtained through providers who have not contracted with the insurance company or self-funded employer). In-Network benefits have less out-of-pocket expense while Out-of-Network benefits are subject to higher copays and deductibles or the full cost of the service. Some medical service(s), such as office visits, preventative services, skilled nursing and hospice coverage are normally restricted to participating providers. There are no referrals required under this type of plan. BCBSM provides a national network of PPO providers accessible out-of-state by using their [Blue Card](#) program. For more information regarding the Blue Card program, call (800) 810-BLUE.

Health Maintenance Organization (HMO)

An HMO is a prepaid health care plan that provides a comprehensive, predetermined medical care benefits package. The patient must choose a primary care physician (PCP) who manages the patient's care including necessary referrals to specialists. The patient must use the HMO network of physician(s) and hospital(s). Except for emergency situations, if the patient chooses to use another physician or hospital outside the HMO network, the payment for those services is usually the responsibility of the patient. Only when the HMO lacks a particular type of medical specialty/service and authorizes the patient to go outside of the HMO network will the cost be paid by the HMO. Participants' out-of-pocket costs are usually the lowest with this type of plan. Regular medical service and coverage may be restricted to areas where the medical provider has a contract. [Health Alliance Plan \(HAP\)](#) provides the HMO plans administered by Wayne County.

High Deductible Health Plan (HDHP)

A High Deductible Health Plan (HDHP) provides comprehensive coverage for high-cost medical events and can provide a tax-advantaged way to help you build savings for future medical expenses when combined with a Health Savings Account (HSA) (see section on HSAs in this Guide for more information). The HDHP gives you greater flexibility and discretion over how you use your health care benefits. Monthly employee contributions are waived for employees enrolling in this plan. In return, a higher deductible must be met before the plan pays for services.

Under the County's HDHP plan provided through [BCBSM](#) under the name *Flexible Blue*, preventative care services, including some prescription drugs considered to be preventative, are fully covered – not subject to deductibles or copays. For all other services, as you receive medical care or fill a prescription, you must meet the plan deductible before the health plan pays benefits. You can choose to pay your deductible with funds from an HSA or FSA you have established, or you may choose instead to pay for your deductible out-of-pocket.

Note: Not all employees are eligible for enrollment in the Flexible Blue HDHP. Check your collective bargaining agreement or benefit plan to determine eligibility or contact the Benefit Administration Division.