Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

Wayne County Legislative Group Retirees

Open Enrollment

November 14 - December 2, 2022

Table of Contents

The purpose of this Open Enrollment Guide is to give you basic information about your benefit options and how to enroll for coverage or make changes to existing coverage. This guide is only a summary of your choices and does not fully describe each benefit option. For a more detailed description of benefits, please refer to the plan's brochure, summary of benefits and coverage (SBC) or evidence of coverage (EOC). You may also call the plan using the customer service phone number on the back cover of this booklet.

Every effort has been made to make the information contained in this booklet accurate; however, if there are discrepancies between this document and the contract with the carrier, the contract will govern.

Highlights of Plan Changes for 2023

Medical / Prescription Drug Plans	**PRE-MEDICARE** Retirees have three Health Plans available. • **Blue Cross Blue Shield of Michigan** (BCBSM) Community Blue PPO • **Blue Cross Blue Shield of Michigan** (BCBSM) Simply Blue HDHP PPO • **Blue Care Network** (BCN) HMO The BCBSM Simply Blue HDHP PPO, is considered to be a Qualified High Deductible Health Plan and allows you to use a Health Savings Account (HSA) which may provide you a tax advantage. Consult with your accountant, banker or financial advisor for more information regarding HSAs. **MEDICARE-ELIGIBLE** Retirees have three Medicare Advantage plans available. • **Blue Cross Blue Shield of Michigan** (BCBSM) Medicare Advantage $1,500 PPO • **Blue Cross Blue Shield of Michigan** (BCBSM) Medicare Advantage $500 PPO • **Blue Care Network** (BCN) Medicare Advantage $500 HMO
Optical Reimbursement Program	Your Optical Reimbursement Program has not changed. You are still automatically eligible to receive a reimbursement of up to $75 per retiree and covered dependent during the two-year policy period beginning October 1 of every odd-numbered year and ending September 30 of the next odd-numbered year.
Voluntary Dental and Vision Plans	A selection of voluntary dental plans and a vision plan continue to be available at the Retiree's sole cost. Enrollment in these plans is handled by TMR & Associates and questions should be directed to them at (313) 963-1135.
Life Insurance and Beneficiary Information	To verify your life insurance and update your beneficiary information, contact the Benefits Division at 313-224-5157 or **benefits@waynecounty.com**.
Enrollment Dates	**Your election of coverage will be accepted no later than December 2, 2022. If you don't want to change your plan, no action is necessary.**

2023 Medical / Prescription Drug Plan Rates for Retirees

Monthly Health Care Contribution Rate Change – January 2023 Change

Medicare Retirees

Once you become eligible for Medicare Parts A and B, you must enroll in Medicare. Enrolling in Medicare is your responsibility. You should contact your Social Security office to enroll in Medicare. Your plan with Wayne County will take assignment of your Original Medicare and provide you with a Medicare Advantage Plan. If you are currently eligible for, but not enrolled in Medicare, you MUST enroll in the 2023 Open Enrollment period. This period runs from January 1 through March 31, 2023. Please see pages 12–14 in this booklet for more information.

If you **and all** of your covered dependents are Medicare eligible, you currently do not pay a monthly contribution toward the cost of your health care plan. If you and / or a dependent are not Medicare eligible, then the applicable monthly contribution rate based upon your labor agreement / benefits plan will apply.

Pre-Medicare Retirees

If you **or any one** of your covered dependents is not Medicare eligible, you are required to pay a monthly contribution toward the cost of your health care plan. If your contribution has not yet reached the maximum retiree monthly contribution rate according to those same terms, your monthly contribution rate is subject to change each year up to a maximum increase of 10% each year based on the change in the insurance carrier's annual renewal rates. The monthly retiree contribution rate is assessed according to the terms of the applicable labor agreement / benefit plan.

Blended Retiree Rate: Some retirees contribute toward the cost of their retiree health care based on a composite calculation. If this applies to you and if your contribution has not yet reached the maximum retiree monthly contribution rate, you will pay 10% of the average monthly rate for each month in which there is at least one person covered who is not yet Medicare eligible. The 2023 blended rate is $201.05 per month.

The retiree contribution rate has not increased since 2017. Although Wayne County has maintained this lower rate over the past four years despite increases in plan costs during that time period, the monthly rate will be increased beginning with the 2022 plan year.

Please be aaware of the following timeline that applies to this Open Enrollment.

Open Enrollment Timeline

Open Enrollment Activity	Dates
Open Enrollment begins	November 14, 2022
Open Enrollment ends	December 2, 2022
Benefit plan elections take effect	January 1, 2023

INFORMATIONAL MEETING SCHEDULE

Wayne County will be holding informational meetings to help you understand the changes taking place in your health care plans.

Informational meetings with Wayne County Benefits staff / representatives and insurance carrier representatives will be held in accordance with the schedule below. You are encouraged to attend a meeting in order to better understand your health plan options.

DATE	TIME	WEBINAR
November 15, 2022	10am-Noon	**https://www.microsoft.com/microsoft-teams/join-a-meeting** **Meeting ID:** 299 309 199 882 **Passcode:** bv5teH
November 17, 2022	2-4pm	**https://www.microsoft.com/microsoft-teams/join-a-meeting** **Meeting ID:** 240 635 449 77 **Passcode:** 4XBxGN

Please visit the Wayne County website (**https://www.waynecounty.com/departments/mb/benefits/benefit-forms-information.aspx**) for more information or call the Benefits Division at 313-224-5157.

QUESTIONS?

Call the Benefits Division at 313-224-5157
or
Email benefits@waynecounty.com

Important Things to Remember

- **Open Enrollment Period ends December 2, 2022.**
- **During Open Enrollment, you have the following options:**
  - Change to a different medical / prescription drug plan.
  - Change coverage levels by adding or deleting dependents.
  - Waive medical / prescription drug plan coverage for the 2023 Plan Year.
- **If you are currently eligible for Medicare, but not enrolled, you MUST enroll in both Medicare Parts A & B during the 2023 Medicare Open Enrollment Period that takes place January 1 through March 31, 2023. Medicare enrollment during this period will be effective July 1, 2023. Any Medicare eligible retirees NOT enrolled in both Medicare Parts A & B will lose Wayne County retiree health benefits on July 1, 2023.**
- **Once Open Enrollment closes**, your selections are binding and cannot be changed, modified or canceled unless you have a qualified life event. See Qualifying Life Event section on page 6 for further details.
- **To Make Your Changes**
  - Fill out the enclosed 2023 Open Enrollment Plan Election Form to ensure that you are enrolled in the plan of your choice
  - Mail the completed form back to Wayne County using the enclosed pre-addressed envelope or fax to 313-967-1228.
  - **If you or a covered dependent are MEDICARE ELIGIBLE and you are changing insurance plans for 2023**, you must also complete a Medicare enrollment application for each Medicare-eligible member from the insurance carrier that you select for enrollment beginning January 1, 2023. The application is part of a pre-enrollment kit available on Wayne County 's benefits website at **https://www.waynecounty.com/departments/mb/benefits/benefit-forms-information.aspx**. The enrollment form can be printed.

  Once completed, this Medicare Advantage enrollment form is to be returned directly to the insurance carrier selected for enrollment, not to Wayne County.
  - *All eligible members (Non-Medicare eligible and Medicare eligible) MUST be enrolled with the same insurance carrier. If, during the open enrollment election process, you do not select the same insurance carrier for all members (Medicare and non-Medicare), we will default the non-Medicare members into the corresponding non-Medicare plan with the insurance carrier chosen by the Medicare-eligible member regardless of any other election to the contrary.*
  - Any benefits change to add or delete dependents requires legal documentation before benefits will be available. See Insurance Coverage for Dependents section on page 5. All changes become effective January 1, 2023.
- **ID Cards:** If you are enrolling into a Medicare Advantage plan for the first time, or are changing carriers, you will receive a new ID card. You should have your new ID card by early January. If you find that you need medical or prescription drug services before you receive your new ID card, contact the insurance carrier for instructions. Contact information for each insurance carrier is provided on the back cover of this Enrollment Guide.

  Blue Cross and Blue Care Network have a mobile app that includes a virtual ID card that can be used at the doctor or pharmacy. If you have a smart phone, you can download this app to access your new ID card on and after January 1, 2023 as your waiting for your physical ID card to arrive in the mail.
- Go to **bcbsm.com/register**, download the BCBSM app, or Text REGISTER to 222764

Insurance Coverage for Dependents

Eligible Dependents Include:

a. **A spouse** — husband or wife, of the opposite or same sex, with whom you are legally married;

b. **An unmarried / married dependent child** regardless of student status until the end of the birth year in which he or she reaches age 26;

c. An unmarried / married dependent child who is incapable of self-support because of a mental and / or physical disability and who depends on you for support.

** Ineligible dependents are: domestic partners and civil union partners, both same sex or opposite sex.*

The term "**Dependent child**" means any of the following:

a. Biological children;

b. Legally adopted children or children placed in the employee's home pending final adoption;

c. Stepchildren;

d. Foster children;

e. Children who are under the legal guardianship of the employee;

f. Children for whom the employee is required to provide health care coverage under a recognized Qualified Medical Child Support Order;

Coverage Effective Date for Newly Enrolled Dependents

Coverage is effective on January 1, 2023 for eligible, newly enrolled dependents.

Dependent Eligibility Verification

In order to provide coverage for your newly enrolled dependents, you must submit proper legal documentation to the Benefits Division no later than January 31, 2023.

Spouse: marriage certificate

Dependent child: birth certificate

Stepchild: birth certificate AND marriage certificate.

Foster child, adopted child or child whom you have legal guardianship: birth certificate AND legal documents from the court.

Age Limits

Dependent children may be covered through the end of the birth year in which they turn 26.

WHAT IF I HAVE QUESTIONS OR NEED ADDITIONAL INFO?

Contact the Benefits Division at 313-224-5157 or email Benefits@waynecounty.com

Qualified Change of Life Events

According to the Internal Revenue Service (IRS) regulations that govern flexible benefit plans, the optional Benefits you elect during enrollment must remain in effect throughout the calendar year, unless you experience a *qualifying change of life event*.

If you decide to change your elections as the result of one of the events listed below, **you must do so within 30 days after the qualifying event**. If you do NOT notify the Benefits Division within 30 days after the event, **you cannot change your elections until the next annual open enrollment**. You must provide the Benefits Division with verification of all change of life events.

Event	Qualified Status Change	How to begin
If you experience a **life change** – such as marriage, legal separation, divorce, birth or adoption of a child, or death	Yes – you have 30 days to notify the Benefits Division and submit required documentation.	• Contact the Benefits Division and make a request to add or drop / delete dependents. • Provide Benefits Division with certified documentation such as a marriage license, birth certificate, divorce decree or other legal document.
If you, your spouse, or eligible dependent child experiences a **change in employment status**	Yes – you have 30 days to notify the Benefits Division and submit required documentation.	• Contact the Benefits Division and make a request to add dependents to your existing plan. • Provide the Benefits Division with proof of previous coverage from the family member's insurance carrier and / or former employer.
If you experience a loss of coverage due to **relocation out of the Plan's coverage area**	Yes – you have 30 days to notify the Benefits Division and submit required documentation.	• Contact the Benefits Division and make a request to enroll in another medical / prescription drug plan. • Provide the Benefits Division with proof of your new residence.
If your physician or facility discontinues participation in plan.	No – you must wait until the next open enrollment to change plans.	• You must wait until the next open enrollment to change plans.

High-level comparison of medical benefit plans

This chart **does not** apply to Medicare Eligible members.
Please see pages 12–14 for Medicare Advantage Plan details.

Plan Benefits	BCBSM Community Blue PPO	BCN Simply Blue HDHP HMO	BCN HMO *In-Network Benefits Only*
Deductibles, Copays and Out-of-Pocket Maximums			
Annual deductible *Full-family deductible MUST be met under a two-person or family contract before any benefits are paid for any person on the contract*	In-Network: $500 for one member, $1,000 for the family (2 or more members) Out-of-network: $1,000 for a single contract or $2,000 for a family contract (2 or more members)	In-Network: $1,500 for a single contract or $3,000 for a family contract (2 or more members) Out-of-network: Not applicable (No coverage Out-of-Network)	In-Network: $500 for one member, $1,000 for the family (2 or more members) Out-of-network: Not applicable (No coverage Out-of-Network)
In-network flat-dollar copays	$30 copay for office visits and office consultations $30 copay for medical online visits $30 copay for chiropractic and osteopathic manipulative therapy $100 copay for emergency room visits $30 copay for urgent care visits	Prescription drugs covered as described after deductible has been met	$5 allergy injections $30 copay for office visits $30 copay for referral physician visits $30 copay for urgent care visits $100 copay for emergency room visits
In-network coinsurance	50% of approved amount for private duty nursing care 50% of approved amount for mental health care and substance use disorder treatment 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)	10% of approved amount for most covered services	50% unless otherwise specified
Out-of-network coinsurance	50% of approved amount for private duty nursing care 50% of approved amount for mental health care and substance use disorder treatment 40% of approved amount for most other covered services	30% of approved amount for most covered services	Not applicable
Annual true out-of- pocket (TROOP) maximums disclosed consistent with Affordable Care Act (ACA) *Includes all out-of-pocket expenses including all in- network deductibles, coinsurance and copays for all services.*	In-Network: $2,000 for one member, $4,000 for a family (2 or more members) Out-of-network: $4,000 for one member, $8,000 for a family (2 or more members)	In-Network: $2,300 for a single-person contract, $4,600 for a family contract (2 or more members) Out-of-network: $4,600 for a single-person contract, $9,600 for a family contract (2 or more members)	In-Network: $6,600 for one member, $13,200 for a family (2 or more members) Out-of-network: Not applicable (No coverage Out-of-Network)

High-level comparison of medical and pharmacy benefits (cont'd)

This chart **does not** apply to Medicare Eligible members.
Please see pages 12–14 for Medicare Advantage Plan details.

Plan Benefits	BCBSM Community Blue PPO	BCN Simply Blue HDHP HMO	BCN HMO *In-Network Benefits Only*
Services in a Hospital			
Number of days of care	Unlimited	Unlimited	Unlimited
Semi-private room and intensive care	Covered 80% after deductible	Covered 90% after deductible	Covered 80% after deductible
Miscellaneous services	Covered 80% after deductible	Covered 90% after deductible	Covered 80% after deductible
Surgery and all related surgical services	Covered 80% after deductible	Covered 90% after deductible	Covered 80% after deductible
Benefits Anesthesia	Covered 80% after deductible	Covered 90% after deductible	Covered 100% after deductible
Laboratory tests and x-rays	Covered 80% after deductible	Covered 90% after deductible	Covered 100% after deductible
Physical therapy	Covered 80% after deductible	Covered 90% after deductible	Covered 100% after deductible
Medicines and drugs	Covered 80% after deductible	Covered 90% after deductible	Covered 100% after deductible
Emergency Care (Medical and Accidental)			
Hospital and physician services	Covered 80% after deductible	Covered 90% after deductible	Covered 100% after deductible
Urgent care facility	$30 copay for urgent care visits	Covered 90% after deductible	Covered 100% after deductible
Ambulance	Covered 80% after deductible	Covered 90% after deductible	Covered 100% after deductible
Physician Services			
Routine / periodic physical exam	Covered 100% once per calendar year	Covered 100% once per calendar year	Covered 100% once per calendar year
Office visits with medical diagnosis	$30 Copay	Covered 90% after deductible	$30 Copay
Consulting specialist care	$30 Copay	Covered 90% after deductible	$30 Copay
Maternity Services Provided by a Physician			
Outpatient post-natal care	100%	Covered 90% after deductible	$30 Copay
Delivery in hospital	Covered 80% after deductible	Covered 90% after deductible	Covered 100% for professional services
Newborn baby care in hospital	Covered 80% after deductible	Covered 90% after deductible	Covered 100% after deductible
Diagnostic and Therapeutic Procedures			
Laboratory tests	Covered 80% after deductible	Covered 90% after deductible	Covered 100%
Radiation therapy	Covered 80% after deductible	Covered 90% after deductible	Covered 100%
Physical, speech & occupational therapy	Covered 80% after deductible	Covered 90% after deductible	$30 Copay
Diagnostic radiology	Covered 80% after deductible	Covered 90% after deductible	Covered 80% after deductible
Preventive Services			

High-level comparison of medical and pharmacy benefits (cont'd)

This chart **does not** apply to Medicare Eligible members.
Please see pages 12–14 for Medicare Advantage Plan details.

Plan Benefits	BCBSM Community Blue PPO	BCN Simply Blue HDHP HMO	BCN HMO *In-Network Benefits Only*
Routine / Preventative Physical Exam	Covered 100% once per calendar year	Covered 100% once per calendar year	Covered 100% once per calendar year
Well-baby care visits	Covered 100%	Covered 100%	Covered 100%
Immunizations	Covered 100%	Covered 100%	Covered 100%
Voluntary Female Sterilization	Covered 100%	Covered 100%	Covered 100%
IUDs ad other contraceptive devices	Covered 100%	Covered 100%	Covered 100%
Mammography screening	Covered 100% once per calendar year	Covered 100% once per calendar year	Covered 100%
Pap Smear	Covered 100%	Covered 100%	Covered 100%
Fecal Occult Blood Screening	Covered 100%	Covered 100%	Covered 100%
Flexible sigmoidoscopy exam	Covered 100%	Covered 100%	Covered 100%
Prostate specific antigen (PSA)	Covered 100%	Covered 100%	Covered 100%
Mental Health Care Services	Covered 50% after deductible	Covered 90% after deductible	$30 Copay
Outpatient psychiatric services	Covered 50% after deductible	Covered 90% after deductible	$30 Copay
Inpatient psychiatric services	Not covered	Covered 90% after deductible	Covered 80% after deductible
Substance Abuse Treatment			
Outpatient substance abuse treatment	Covered 50% after deductible	Covered 90% after deductible	$30 Copay
Inpatient substance abuse treatment	Not covered	Covered 90% after deductible	Covered 100% after deductible
Alternative to Hospital Care			
Skilled nursing facility	Covered 80% after deductible (limited to 120 per year)	Covered 90% after deductible (limited to 90 per year)	Covered 100% after deductible (up to 45 per year)
Home health care	Covered 80% after deductible		Covered 80% after deductible
Custodial care facility	Not covered	Not covered	Not covered
Hospice care facility	Covered 100%	Covered 90% after deductible	Covered 100% after deductible
Chiropractic services	$30 Copay	Covered 90% after deductible	$30 Copay
Appliances and Prosthetic Devices	Covered 80% after deductible	Covered 90% after deductible	Covered 50%
Durable Medical Equipment	Covered 80% after deductible	Covered 90% after deductible	Covered 50%
Hearing Services			
Hearing screening	Not covered	Not covered	Not covered
Hearing examination	Covered 80% after deductible with medical diagnosis only	Covered 90% after deductible with medical diagnosis only	Covered 100% after deductible with medical diagnosis only
Hearing aids	Not covered	Not covered	Not covered

High-level comparison of medical and pharmacy benefits (cont'd)

This chart **does not** apply to Medicare Eligible members.
Please see pages 12–14 for Medicare Advantage Plan details.

Plan Benefits	BCBSM Community Blue PPO	BCN Simply Blue HDHP HMO	BCN HMO *In-Network Benefits Only*
Prescription Drugs			
Tier 1 Generic drugs *(30-day supply)*	$10 Copay	Covered with $10 copay after deductible	$10 Copay
Tier 2 Preferred brand-name drugs *(30-day supply)*	$35 Copay	Covered with $35 copay after deductible	$35 Copay
Tier 3 Nonpreferred brand-name drugs *(30-day supply)*	$50 Copay	Covered with $50 copay after deductible	$50 Copay
Mail-order drug / 90-day retail *(00-day supply)*	2 times 30-day supply copay	2 times 30-day supply copay after deductible	2 times 30-day supply copay
Other features	Custom Formulary Mandatory preauthorization Step Therapy 90-day retail program	Custom Formulary Mandatory preauthorization Step Therapy 90-day retail program	Custom Formulary Mandatory preauthorization Step Therapy 90-day retail program

High-level comparison of medical and pharmacy benefits (cont'd)

This chart **does not** apply to Medicare Eligible members.
Please see pages 12–14 for Medicare Advantage Plan details.

Medicare-Eligible Retirees and Dependents

Wayne County requires that its retirees enroll for Medicare Parts A & B when eligible. Most people become eligible at age 65 but you could become eligible sooner if disabled. You should receive information from the Social Security Administration when you become eligible for Medicare; however, if you do not, **it is your responsibility to contact them**. Failure to enroll in Medicare Parts A & B will compromise your eligibility for Wayne County medical and prescription drug benefits and / or subject you to permanent premium penalties from the Center of Medicare and Medicaid Services (CMS).

Once you are enrolled in Medicare Parts A & B, you must send a copy of your Medicare ID card to the Wayne County Benefits Division so that we can ensure that you are enrolled in the proper medical and prescription drug plans. BCBSM members are moved into the BCBSM Medicare Advantage Plan, and BCN members are moved into the BCN Medicare Advantage Plan.

You should not enroll in an **individual** Medicare Advantage or Medicare Advantage Part D program if you are enrolled in one of the Wayne County health insurance plans, because Medicare does not allow you to enroll in two Medicare Advantage plans at the same time. Enrolling in an individual plan will terminate your coverage under the Wayne County sponsored medical and prescription drug coverage.

Medicare Advantage Summary

Medicare Advantage Plans, sometimes called "Part C" or "MA Plans" are a type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Parts A & B benefits. If you join a Medicare Advantage Plan, you still have Medicare. You will receive your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage Plan and not Original Medicare. In all types of Medicare Advantage Plans, you are always covered for emergency and urgently needed care.

Medicare Advantage Plans may offer extra coverage, like health and wellness programs. All plans offered by Wayne County include Medicare prescription drug coverage (Part D).

You must continue to pay your Part B premium, even when enrolled in a Medicare Advantage Plan.

Medicare Advantage Frequently Asked Questions

1. **WILL I RECEIVE A NEW CARRIER ID CARD WHEN I JOIN A MEDICARE ADVANTAGE PLAN?**
   Yes. When enrolling in a Medicare Advantage Plan for the first time or when changing carriers, you will receive an ID card from the carrier which you will use when receiving care. Your Original Medicare (red, white, and blue) Card can be put in a safe place. You will not be using your Original Medicare Card while enrolled in Medicare Advantage.

2. **I'M TURNING 65 THIS YEAR, HOW DOES MEDICARE WORK WITH MY INSURANCE?**
   You must enroll in Medicare Parts A & B when eligible. Wayne County's insurance carriers will auto enroll you into the Medicare Advantage Plan once the Benefits Division receives a copy of your Medicare ID card. If you are enrolled in BCBSM, you will transition to the BCBSM Medicare Advantage Plan. If you are enrolled in BCN, you will transition to the BCN Medicare Advantage Plan.

3. **WHAT IF I'M NOT 65, BUT HAVE MEDICARE PARTS A & B DUE TO A DISABILITY?**

IMPORTANT:

If your current coverage includes both Medicare and non-Medicare eligible members, ALL members must be covered by the same insurance carrier. For example, if a Medicare eligible member selects a BCN Medicare Advantage plan, ALL remaining members must be enrolled in a BCN plan. If, during the open enrollment election process, you do not select the same insurance carrier for all members (Medicare and non-Medicare), we will default the non-Medicare members into the corresponding non-Medicare plan with the insurance carrier chosen by the Medicare eligible member regardless of any other election to the contrary.

You must submit a copy of your Medicare ID card to the Wayne County Benefit Division so that Wayne County's insurance carriers can enroll you into the Medicare Advantage Plan.

4. **WHAT HAPPENS TO MY PRESCRIPTION COVERAGE WHEN I AM ELIGIBLE FOR MEDICARE PARTS A & B?**
   Your Wayne County Medicare Advantage Plan includes coverage for prescription drugs. You should not enroll in an individual Medicare Part D plan on your own if you wish to be covered by the Wayne County plan. If you enroll in a Medicare Part D plan on your own, your coverage through Wayne County will automatically be cancelled because the Federal government does not allow coverage under two Medicare Part D plans.

5. **WHAT IF MY SPOUSE TURNS 65 BEFORE ME or I TURN 65 BEFORE MY SPOUSE?**
   When one member is enrolling in Medicare, your Wayne County insurance enrollment is modified from a "two-person" or "family" plan to a "split plan." The Medicare-eligible enrollee will have the Medicare Advantage Plan, while the other member who is not eligible for Medicare will continue with their current plan.

6. **WHAT HAPPENS TO MY MONTHLY BENEFIT DEDUCTION?**
   Once the Benefits Division has a copy of your Medicare ID card to verify you have successfully enrolled in Medicare Parts A & B, your monthly deductions will be updated based upon your applicable labor agreement/benefit plan. Medicare Advantage Plans are currently provided with no retiree contribution.

7. **WHAT IF I HAVE QUESTIONS OR NEED ADDITIONAL FORMS?**
   You may contact the Benefits Division at 313-224-5157 or email Benefits@waynecounty.com. Please leave your full name, home address and phone number.

Medicare Advantage High-level benefit comparison

	BCBSM Medicare Plus Blue, in-network	BCBSM Medicare Plus Blue, in-network	BCN Advantage HMO-POS
Deductible	$1,500	$500	$500
Fixed dollar copays	$75 ER visits $20 chiropractic visits	$30 office visits $30 urgent care visits $75 ER visits $20 chiropractic visits	$30 office visits $30 urgent care $75 ER visits $20 chiropractic visits
Coinsurance	10%	20%	None
Maximum Out-of-Pocket	$2,300	$2,000	$6,700
Preventive Care services			
Annual Wellness Visit	100%	100%	100%
Colorectal cancer screenings	100%	100%	100%
Immunization	100%	100%	100%
Mammogram	100%	100%	100%
Physician office services			
Chiropractic care	$20	$20	$20
Office visit	Covered 90% after deductible	$30	$30
Specialist visit	Covered 90% after deductible	$30	Covered $30 copay after deductible
Outpatient physical, speech and occupational therapy	Covered 90% after deductible	Covered 80% after deductible	Covered $30 copay after deductible
Emergency medical care			
Ambulance Services	Covered 90% after deductible	Covered 80% after deductible	Covered 100%
Emergency room care	$75 copay	$75 copay	$75 copay
Urgent care	Covered 90% after deductible	$30 copay	$30 copay
Diagnostic services			
Diagnostic tests and x-rays	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible, office visit copay may apply
Radiology imaging (MRI, MRA, CAT scan, PET)	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible
Laboratory and pathology services	Covered 90% after deductible	Covered 80% after deductible	Covered 100%, office visit copay may apply
Hospital Care			
Inpatient care	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible, unlimited days
Outpatient surgery	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible

Alternatives to hospital care			
Home health care	Covered 100%	Covered 100%	Covered 100% after deductible, physician visit copay may apply
Skilled Nursing care	Covered 90% after deductible, up to 120 days per benefit period	Covered 80% after deductible, up to 120 days per benefit period	Covered 100% after deductible, up to 100 days per benefit period
Surgical services			
Human organ transplants	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible
Surgery	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible
Mental health care and substance use treatment			
Inpatient mental health care	Covered 90% after deductible	Covered 80% after deductible	Covered 100%, unlimited days
Inpatient substance use disorder	Covered 90% after deductible	Covered 80% after deductible	Covered 100%, unlimited days
Outpatient mental health care	Covered 90% after deductible	Covered 80% after deductible	Covered 100%, unlimited days
Outpatient substance use disorder	Covered 90% after deductible	Covered 80% after deductible	Covered 100%, unlimited days
Durable Medical Equipment, Prosthetics & Orthotics			
Durable medical equipment	Covered 90% after deductible	Covered up to 100%	Covered 100%
Prosthetic and orthotic appliances	Covered 90% after deductible	Covered up to 100%	Covered 100%
Additional Services			
SilverSneakers® fitness program	100%	100%	100%
Prescription Drugs	Preferred/Standard Copays – up to a 31-day supply	Preferred/Standard Copays – up to a 31-day supply	Preferred/Standard Copays – up to a 31-day supply
Tier 1 – Preferred Generic	$4/$10	$4/$10	$3/$10
Tier 2 – Generic	$4/$10	$4/$10	$3/$10
Tier 3 – Preferred Brand	$25/$35	$25/$35	$30/$35
Tier 4 – Non-preferred Drug	$40/$50	$40/$50	$40/$50
Tier 5 – Specialty Tier	$40/$50	$40/$50	$40/$50
Mail-order prescription drugs	Two times the applicable generic and brand copay for a 32-day to a 90-day supply.		
Phases 3 & 4: The Coverage Gap & The Catastrophic Stages			
Once member's out-of-pocket costs reach over $7,400 the copay is the greater of 5% of $4.15 for generic drugs and $10.35 for brand-name drugs, not to exceed base copay. Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage. For more information about your costs in these stages, look at Chapter 6, Section 6 and 7, in the *Evidence of Coverage* online at **www.bcbsm.com/medicare**.			

Chart is a high-level comparison of in-network benefit deductibles, coinsurances, copays, and out of pocket maximums. Refer to benefit charts for a detailed description of covered services.

Important Notice from WAYNE COUNTY Regarding

PRESCRIPTION DRUG COVERAGE AND MEDICARE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, please read this important notice.

Please read this Notice carefully and keep it where you can find it. This Notice has information about your current prescription drug coverage with Wayne County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this Notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Wayne County has determined that the prescription drug coverage that they offer is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage with Wayne County is, on average, at least as good as or better than standard Medicare prescription drug coverage, you can keep this coverage, still use the same pharmacy network, keep the same affordable co-payments for prescription drugs, and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. If you lose or decide to leave Wayne County coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare drug coverage in your area.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to enroll in a Medicare prescription drug plan and drop your Wayne County coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact Wayne County H/R Benefits Department for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Continued on next page…

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your coverage with Wayne County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have a Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact Wayne County H/R Benefits for further information.

NOTE: You will receive this Notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if Wayne County coverage changes. You also may request a copy at any time.

For More Information About Your Options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the 'Medicare & You' handbook for their telephone number).
- For personalized help, call 1-800-Medicare (1-800-633- 4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER:

Keep this Creditable Coverage Notice.

If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this Notice when you join to show whether or not you have maintained Creditable Coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	**September 2022**
Entity/Sender:	**The Charter County of Wayne**
Contact:	**The Wayne County Benefits Team**
Address:	**500 Griswold Street, 14th Floor Detroit, MI 48226**
Phone:	**(313) 224-5157**

CMS Form 10182-CC
Updated by CMS: TBD
Updated by Wayne County: TBD

Important Notice from the CHARTER COUNTY OF WAYNE Regarding

MEDICARE D NOTICE OF PRESCRIPTION DRUG CREDITABLE COVERAGE ADMINISTRATOR'S INFORMATION SHEET

Due Date of Notice

The Medicare D Notice of Prescription Drug Creditable Coverage must be provided annually by **October 15th**.

Who Must Get The Notice?

The Notice must be provided to an individual **covered under the plan that is eligible for Medicare**, this includes Medicare-eligible active employees, retirees (except retirees covered under an EGWP, an "Employer Group Waiver Plan"), disabled employees, and individuals on COBRA (and the preceding individuals covered Medicare-eligible spouses).

Note: You are not prohibited from sending the Notice to all retirees or active employees if the County cannot reasonably identify which of those active employees, retirees, disabled employees and individuals on COBRA has a Medicare-eligible spouse covered under the plan.

Other Times That The Notice Must be Provided?

The Notice must be provided to an individual at the following times:

1. Before the individual's initial opportunity to enroll in Medicare Part D,
2. Before the effective date of coverage for a Medicare-eligible individual joining the plan after the annual notice was distributed,
3. When the prescription drug coverage under the plan ends or it's creditable coverage status changes, and
4. Upon the request of a Medicare-eligible individual covered under the plan.

Delivery Method of Notice

The following methods may be used to distribute the Notice:

1. Distribution by Mailing.
   a. The Notice can but does not need to be sent in a separate mailing. It can be sent along with other disclosure material as long as the Notice is "prominent and conspicuous.
   b. A single Notice can be sent to a covered Medicare-eligible individual and the individual's spouse that is covered under the plan. However, a separate Notice is required to be sent to a covered Medicare-eligible individual and the individual's spouse covered under the plan if "it is known" that the Medicare-eligible spouse resides at a different address than the address that the Notice is being sent
2. Electronic Distribution.

   Electronic distribution is permissible for participants that have the ability to access electronic documents on their employer's information system on a daily basis at their regular place of work as part of their work duties.

Important Notice from the CHARTER COUNTY OF WAYNE Regarding

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Federal Women's Health and Cancer Rights Act of 1998 requires that benefits must be provided for:

- Reconstruction of a surgically removed breast;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment for physical complications from all stages of mastectomy, including lymph edemas

These benefits are subject to applicable terms and conditions under your health plan, including copayments, deductible and coinsurance provisions. They are also subject to medical insurance limitations and exclusions.

Updated: August 2008

Important Notice from the CHARTER COUNTY OF WAYNE Regarding

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

The law provides protections on the length of time mothers and their newborn infants may stay in the hospital following childbirth. Under its "general rule," group health plans and health issuers may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours (or 96 hours following a cesarean section). An exception provides that an attending provider, in consultation with the mother, is free to authorize an earlier discharge. The final rules generally follow the interim rules adopted in 1998, clarifying certain issues, including that:

- The attending provider determines that an admission is in connection with childbirth and when the hospital stay begins for purposes of applying the general rule, and that provider determines when an exception to the 48-hour or 96-hour general rule will be taken in consultation with the mother. The final rules clarify the definition of "attending provider" to specifically exclude a plan, hospital, managed care organization or other issuer.
- ERISA-covered group health plans are required to comply with the ERISA notice regulations, whether insured or self-insured. The final rules clarify that ERISA group health plans can provide the notice electronically.
- A state law exemption applies when a state law requires health insurance coverage in accordance with professional guidelines. The final rules clarify that the exemption will apply if the state law simply requires coverage in accordance with professional guidelines that deal with care following childbirth, and not necessarily other care issues in connection with childbirth.

The final regulations, effective Dec. 19, 2008, apply to group health plans and group health issuers for plan years beginning on or after Jan. 1, 2009.

Updated: July 2009

Important Notice from the CHARTER COUNTY OF WAYNE Regarding

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility.

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: **http://myalhipp.com/** Phone: 1-855-692-5447	Website: **https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_c ont.aspx** Phone: 916-440-5676
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: **http://myakhipp.com/** Phone: 1-866-251-4861 Email: **CustomerService@MyAKHIPP.com** Medicaid Eligibility: **http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx**	Health First Colorado Website: **https://www.healthfirstcolorado.com/** Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: **https://www.colorado.gov/pacific/hcpf/child-health-plan-plus** CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): **https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program** HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: **http://myarhipp.com/** Phone: 1-855-MyARHIPP (855-692-7447)	Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrec overy.com/hipp/index.html** Phone: 1-877-357-3268

Continued on next page…

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp** Phone: 678-564-1162 ext 2131	Website: **http://www.mass.gov/eohhs/gov/departments/masshealth/** Phone: 1-800-862-4840
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: **http://www.in.gov/fssa/hip/** Phone: 1-877-438-4479 All other Medicaid Website: **https://www.in.gov/medicaid/** Phone 1-800-457-4584	Website: **https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp** Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: **https://dhs.iowa.gov/ime/members** Medicaid Phone: 1-800-338-8366 Hawki Website: **http://dhs.iowa.gov/Hawki** Hawki Phone: 1-800-257-8563	Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: **http://www.kdheks.gov/hcf/default.htm** Phone: 1-800-792-4884	Website: **http://dphhs.mt.gov/** MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328** Email: **KIHIPP.PROGRAM@ky.gov** KCHIP Website: **https://kidshealth.ky.gov/Pages/index.aspx** Phone: 1-877-524-4718 Kentucky Medicaid Website: **https://chfs.ky.gov**	Website: **http://www.ACCESSNebraska.ne.gov** Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: **www.medicaid.la.gov or www.ldh.la.gov/lahipp** Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: **http://dhcfp.nv.gov** Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: **https://www.maine.gov/dhhs/ofi/applications-forms** Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: **https://www.maine.gov/dhhs/ofi/applications-forms** Phone: 1-800-977-6740. TTY: Maine relay 711	Website: **https://www.dhhs.nh.gov/oii/hipp.htm** Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

Continued on next page…

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA – Medicaid
Medicaid Website: **http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/** Medicaid Phone: 609-631-2392 CHIP Website: **http://www.njfamilycare.org/index.html** CHIP Phone: 1-800-701-0710	Website: **http://dss.sd.gov** Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: **https://www.health.ny.gov/health_care/medicaid/** Phone: 1-800-541-2831	Website: **http://gethipptexas.com/** Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: **https://medicaid.ncdhhs.gov/** Phone: 919-855-4100	Medicaid Website: **https://medicaid.utah.gov/** CHIP Website: **http://health.utah.gov/chip** Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: **http://www.nd.gov/dhs/services/medicalserv/medicaid/** Phone: 1-844-854-4825	Website: **http://www.greenmountaincare.org/** Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: **http://www.insureoklahoma.org** Phone: 1-888-365-3742	Website: **https://www.coverva.org/hipp/** Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: **http://healthcare.oregon.gov/Pages/index.aspx** **http://www.oregonhealthcare.gov/index-es.html** Phone: 1-800-699-9075	Website: **https://www.hca.wa.gov/** Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: **https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx** Phone: 1-800-692-7462	Website: **http://mywvhipp.com/** Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN–Medicaid and CHIP**
Website: **http://www.eohhs.ri.gov/** Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm** Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: **https://www.scdhhs.gov** Phone: 1-888-549-0820	Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/** Phone: 1-800-251-1269

Continued on next page…

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

HIPAA NOTICE OF PRIVACY PRACTICES

For Protected Health Information for Its Employee and Retiree Medical, Dental, Vision, Employee Reimbursement Account, and Employee Assistance Program Health Plans

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

This is your Notice of Privacy Practices provided by the County of Wayne ("County"). This notice refers to the County by using the terms "us," "we," or "our."

The County must collect information about you to provide you with health insurance. We know that information we collect about you and your health is private. The County is required to protect this information by federal and state law.

This notice will tell you how we may use or disclose information about you. Not all situations will be described. The County is required to give you a notice of our privacy practices for the information we collect, keep and disclose about you. We are required to follow the terms of the notice currently in effect.

The Genetic Information Discrimination Act of 2008 (GINA) includes provisions related to genetic information that affect HIPAA nondiscrimination rules. Genetic information is defined as information about genetic tests of an individual or an individual's family members, information about the manifestation of a family member's disease or disorder and an individual's request for or receipt of genetic services. Effective May 21, 2009, GINA mandates that a group health plan cannot:

- Adjust premiums or contribution amounts based on genetic information;
- Request or require an individual or an individual's family member to undergo a genetic test;
- Request, require or purchase genetic information prior to or in connection with enrollment in the plan; or
- Use genetic information for underwriting purposes

Group health plans may use the results of genetic tests for payment purposes explained below, as long as the minimum amount of information necessary is used.

HOW WAYNE COUNTY MAY USE AND DISCLOSE INFORMATION WITHOUT YOUR AUTHORIZATION

- **For Payment:** We may use or disclose information to pay for the health care services you receive. For example, the County may receive and review health information contained on claims to reimburse providers for services rendered or to verify insurance enrollment and eligibility information with providers seeking to receive payment for healthcare services provided to you or your covered dependents.
- **For Health Care Operations:** We may use or disclose health information for our insurance operations or to manage our programs or activities. For example, we may use PHI to process transactions requested by you, to review the quality of services you receive or to audit the services for which our insurance carriers have been contracted to perform.
- **Where Required by Law or for Law Enforcement:** We will use and disclose information when required by law. Examples of such releases would be for law enforcement or national security purposes, subpoenas or other court orders, disaster relief, review of our activities by government agencies, to avert a serious threat to health or safety or in other kinds of emergencies.

Continued on next page…

- **When Required for Public Health Activities:** We disclose information when required by federal, state or local law. Examples of such mandatory disclosures include notifying state or local health authorities about communicable diseases, or providing information to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death.
- **For Health-Related Benefits or Services:** We may use health information to provide you with information about benefits available to you under your current Insurance coverage and, in limited situations, about health-related products or services that may be of interest to you
- **When Requested as Part of a Regulatory or Legal Proceeding:** If you or your estate are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may disclose Protected Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.
- **For Government Programs:** We may use and disclose information for public benefits under other government programs. For example, we may disclose information for the determination of benefits under Medicare
- **Disclosures to Family, Friends and Others:** We may disclose information to your family or other person(s) who are involved in your medical care or payment for your medical care. You have the right to object to the sharing of this information.
- **Other Uses of Health Information:** For other situations, the County will ask for your written authorization before using or disclosing information.

YOUR PRIVACY RIGHTS

- **Right to See and Get Copies of Your Records:** In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.
- **Right to Amend Your Records:** You may ask the County to change or add missing information to your records if you think there is a mistake. You must make the request in writing and provide a reason for your request.
- **Right to Get a List of Disclosures:** You may request a list of disclosures made after April 14, 2003. You must make the request in writing. This list will not include the times that information was disclosed for payment or health care operations or releases required by law or for law enforcement. The list also will not include information provided directly to you or information that was sent with your authorization.
- **Right to Request Limits on Uses or Disclosures:** You may request that the County limit how information is used or disclosed. You must make the request in writing and tell us what information you want to limit and to whom you want the limits to apply. The County is not required to agree to the limitation. You can request, in writing, that the limitation be terminated or the County may terminate the limitation with advance notice to you.
- **Right to Request Confidential Communications:** You may request that we share information with you in a certain way or in a certain place. For example, you may ask us to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the reason for your request.
- **Right to Revoke Authorization:** If you are asked to sign an authorization to use or disclose information, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been disclosed under the authorization.
- **Right to File a Complaint:** You have the right to file a complaint if you do not agree with how the County has used or disclosed information about you.
- **Right to Get a Paper Copy of this Notice:** You have the right to ask for a paper copy of this notice at any time.

Continued on next page…

COMMUNICATIONS ABOUT YOUR RIGHTS

You may contact the County to:

- Ask to look at or copy your records
- Ask to limit how information about you is used or disclosed
- Ask to cancel your authorization
- Ask to amend your records
- Ask for a list of the times the County disclosed information about you

The County may deny your request to look at, copy or amend your records. If the County denies your request, it will send you a letter that tells you why your request is being denied and how you can ask for a review of the denial. You will also receive information about how to file a complaint with the County or with the U.S. Department of Health and Human Services, Office of Civil Rights.

If you wish to ask questions about this notice, exercise your rights under this notice, communicate with us about privacy issues or file a complaint, you can contact us at:

HIPAA Privacy & Security Dir. /
HIPAA Compliance
Wayne County Health & Human Services
500 Griswold Street,10th Floor
Detroit, Michigan 48226
(313) 224-5109
Email: HIPAAPrivacyOfficer@waynecounty.com

You may file a complaint with the federal government at:

U.S. Office of Civil Rights:
Medical Privacy, Complaint Division
U.S. Department of Health and Human Services 200 Independence Avenue, SW
Washington, DC 20201
(866) 627-7748
TTY: (866) 788-4989
Email: ocrprivacy@hhs.gov

Changes to This Notice: We reserve the right to revise this notice at any time. The revised notice will be effective for health information we already have about you as well as any information we may receive in the future. We are required to comply with whatever notice is currently in effect. Any changes to our notice will be published on our website. Go to **www.waynecounty.com** and click on the HIPAA icon. A copy of the new notice will be posted at each County site and facility and provided as required by law. You may ask for a paper copy of the current notice anytime.

Updated: July 2012

Wayne County Service Contacts

Benefits Division

Benefits@WayneCounty.com

www.waynecounty.com/departments/mb/benefits-disability.aspx

313-224-5157

Other Contacts

Blue Care Network

www.bcbsm.com

1-800-662-6667

Blue Care Network Advantage

www.bcbsm.com

1-800-450-3680

Blue Cross Blue Shield of Michigan

www.bcbsm.com

1-877-790-2583

Blue Cross Blue Shield of Michigan Medicare Plus Blue

www.bcbsm.com

1-877-241-2583

Centers for Medicare and Medicaid Services

www.cms.gov

1-800-633-4227

TTY: 877-486-2048

Social Security Administration

www.ssa.gov

1-800-772-1213

TTY 1-800-325-0778

Blue Cross
Blue Shield
Blue Care Network
of Michigan

Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association