



**MI HR
Service Center**

The MI HR Service Center can assist you with questions and enrolling in these benefit plans.

*Department of Civil Service
MI HR Service Center*

*P.O. Box 30002
Lansing, Michigan 48909*

Phone (877) 766-6447

Fax (517) 241-5892

<http://www.michigan.gov/selfserv>

Hours

7:00 a.m. – 6:00 p.m.
Monday – Friday, except holidays

Detailed benefit information, including benefit booklets and insurance rates, is also available on-line at:

www.michigan.gov/mdcs

Click “Employee Benefits” from the left toolbar and then click “New Employee”.

Benefit Comparison Chart & Biweekly Insurance Rates



For the benefit year
October 2004 – September 2005



Notes:

Disclaimer

This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and /or co-pay amounts required by the State Health Plan PPO. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan.

Comparison of Health Care Options

Preventive Services

\$750 per year per person (State Health Plan PPO only)

	State Health Plan PPO <small>(does not apply to members represented by MSPTA T01)</small>		HMO Benefits
	In-network	Out-of-network	
Health maintenance exam	Covered -100% 1 per year	Not Covered	100% covered after \$10 office visit co-payment
Annual gynecological exam	Covered - 100% 1 per calendar year	Not Covered	
Pap smear screening – laboratory services only ¹	Covered - 100% 1 per year	Not Covered	
Well-baby and child care	Covered - 100%	Not Covered	
Immunizations, annual flu shot & Hepatitis C screening for those at risk	Covered - 100%	Not Covered	
Fecal occult blood screening ¹	Covered - 100%	Not Covered	
Flexible sigmoidoscopy ¹	Covered - 100%	Not Covered	
Colonoscopy ¹	Covered - 100%	Not Covered	
Prostate specific antigen screening ¹	Covered - 100% one per year	Not Covered	

¹ American Cancer Society guidelines apply

Mammography¹

	State Health Plan PPO <i>(does not apply to members represented by MSPA T01)</i>		HMO Benefits
	In-network	Out-of-network	
Annual standard film mammography screening (covers digital mammography up to the standard film rate)	Covered - 100% Not subject to preventative maximum	Covered -90% after deductible Not subject to preventative maximum	Covered 100%

Physician Office Services

	State Health Plan PPO <i>(does not apply to members represented by MSPA T01)</i>		HMO Benefits
	In-network	Out-of-network	
Office visits, consultations & urgent care visits	Covered \$10 co-pay Deductible not applicable	Covered -90% after deductible	\$10 co-pay
Outpatient and home visits	Covered – 100% after deductible	Covered -90% after deductible	

Emergency Medical Care²

	State Health Plan PPO <i>(does not apply to members represented by MSPA T01)</i>		HMO Benefits
	In-network	Out-of-network	
Hospital emergency room for medical emergency or accidental injury	Covered – 100%		\$50 co-pay if not admitted
Ambulance services – medically necessary	Covered – 100% after deductible		Covered 100%

¹ American Cancer Society guidelines apply

² Emergency room and physician charges are covered 100% under the Catastrophic Health Plan. Ambulance is covered \$25 maximum.

Dental Premium Rates

Effective October 10, 2004

	Option*	BIWEEKLY RATE		
		Employee	State	Total
State Dental Plan	1	\$ 0.83	\$ 15.77	\$ 16.60
	2	\$ 1.51	\$ 28.78	\$ 30.29
	3	\$ 1.84	\$ 35.05	\$ 36.89
	4	\$ 2.53	\$ 48.01	\$ 50.54
Preventive Dental Plan (State pays 100%)	1		\$ 2.99	\$ 2.99
	2		\$ 5.21	\$ 5.21
	3		\$ 5.21	\$ 5.21
	4		\$ 7.42	\$ 7.42
Midwest Dental (DMO) (State pays 100%)	1		\$ 15.99	\$ 15.99
	2		\$ 15.99	\$ 15.99
	3		\$ 15.99	\$ 15.99
	4		\$ 15.99	\$ 15.99

Dependent Life Premium Rates

Effective October 10, 2004

	Option	BIWEEKLY RATE		
		Employee	State	Total
Spouse \$1,500 and/or Child(ren) \$1,000	F	\$.20		\$.20
Spouse \$5,000 and/or Child(ren) \$2,500	G	\$.60		\$.60
Spouse \$10,000 and/or Child(ren) \$5,000	H	\$ 1.20		\$ 1.20
Spouse \$25,000 and/or Child(ren) \$10,000	K	\$ 4.00		\$ 4.00
Child(ren) only \$10,000	L	\$.75		\$.75

Group Insurance Premium Rates

Effective October 10, 2004

	Option*	BIWEEKLY RATE		
		Employee	State	Total
HealthPlus of Michigan	1	\$ 7.67	\$ 160.12	\$ 167.78
	2	\$ 15.34	\$ 320.23	\$ 335.57
	3	\$ 13.50	\$ 281.80	\$ 295.30
	4	\$ 21.16	\$ 441.92	\$ 463.08
M-Care HMO	1	\$ 4.63	\$ 160.12	\$ 164.75
	2	\$ 9.28	\$ 320.23	\$ 329.51
	3	\$ 8.16	\$ 281.80	\$ 289.96
	4	\$ 12.80	\$ 441.92	\$ 454.72
Physicians Health Plan Lansing	1	\$ 7.51	\$ 160.12	\$ 167.63
	2	\$ 13.70	\$ 320.23	\$ 333.93
	3	\$ 11.76	\$ 281.80	\$ 293.57
	4	\$ 18.67	\$ 441.92	\$ 460.59
Physicians Health Plan Jackson	1		\$ 160.12	\$ 160.12
	2		\$ 320.23	\$ 320.23
	3		\$ 281.80	\$ 281.80
	4		\$ 441.92	\$ 441.92
Priority Health Plan	1	\$ 2.18	\$ 160.12	\$ 162.30
	2	\$ 4.51	\$ 320.23	\$ 324.74
	3	\$ 3.90	\$ 281.80	\$ 285.70
	4	\$ 6.08	\$ 441.92	\$ 448.00
Total Health Care	1		\$ 117.08	\$ 117.08
	2		\$ 234.17	\$ 234.17
	3		\$ 206.07	\$ 206.07
	4		\$ 323.95	\$ 323.95

Vision Premium Rates

Effective October 10, 2004

	Option*	BIWEEKLY RATE		
		Employee	State	Total
State Vision Plan (State pays 100%)	1		\$ 2.65	\$ 2.65
	2		\$ 4.65	\$ 4.65
	3		\$ 5.68	\$ 5.68
	4		\$ 7.69	\$ 7.69

* Health, dental and vision option codes are: 1 = Employee only coverage, 2 = Employee & Spouse, 3 = Employee & Child(ren), 4 = Full Family

Diagnostic Services

	State Health Plan PPO <i>(does not apply to members represented by MSPTA T01)</i>		HMO Benefits
	In-network	Out-of-network	
Laboratory & pathology tests	Covered – 100% after deductible	Covered -90% after deductible	Covered 100%
Diagnostic tests & x-rays			
Radiation therapy			

Maternity Services

Includes care by a certified nurse midwife (State Health Plan PPO only)

	State Health Plan PPO <i>(does not apply to members represented by MSPTA T01)</i>		HMO Benefits
	In-network	Out-of-network	
Prenatal & postnatal care	Covered – 100% after deductible	Covered -90% after deductible	Office Visit \$10 co-pay
Delivery & nursery care ³			Covered 100%

³ Delivery and well-baby care in the hospital are covered 100% under the Catastrophic Health Plan.

Hospital Care

	State Health Plan PPO <i>(does not apply to members represented by MSPTA T01)</i>		HMO Benefits
	In-network	Out-of-network	
Semi-private room, inpatient physician care, general nursing care, hospital services and supplies	Covered – 100% after deductible, unlimited days	Covered -90% after deductible, unlimited days	Covered 100% Unlimited days
Inpatient consultations	Covered – 100% after deductible	Covered -90% after deductible	Covered 100%
Chemotherapy			

Alternatives to Hospital Care

	State Health Plan PPO <i>(does not apply to members represented by MSPTA T01)</i>		HMO Benefits
	In-network	Out-of-network	
Skilled nursing care up to 120 days per confinement (730 days for UAW)	Covered – 100% after deductible	Covered – 100% after deductible	Covered 100% up to 730 days
Hospice care	Covered 100% Limited to the lifetime dollar maximum that is adjusted annually by the state		Covered 100%
Home health care	Covered 100% After deductible, unlimited visits		

Surgical Services

	State Health Plan PPO <i>(does not apply to members represented by MSPTA T01)</i>		HMO Benefits
	In-network	Out-of-network	
Surgery – includes related surgical services. ⁴	Covered – 100% after deductible	Covered – 90% after deductible	Covered 100%
Voluntary sterilization			

⁴ Inpatient hospital services are 100% covered after deductible under the Catastrophic Health Plan.

Human Organ Transplants

	State Health Plan PPO <i>(does not apply to members represented by MSPTA T01)</i>		HMO Benefits
	In-network	Out-of-network	
Liver, heart, lung, pancreas and other specified organ transplants	Covered 100% In designated facilities only. Up to \$1 million lifetime maximum for each organ transplant		Covered 100% in designated facilities

Biweekly Insurance Rates

Group Insurance Premium Rates

Effective October 10, 2004

	Option*	BIWEEKLY RATE		
		Employee	State	Total
State Health Plan	1	\$ 8.42	\$ 160.12	\$ 168.54
	2	\$ 16.85	\$ 320.23	\$ 337.08
	3	\$ 14.83	\$ 281.80	\$ 296.63
	4	\$ 23.26	\$ 441.92	\$ 465.18
Catastrophic Health Plan (State pays 100%)	1		\$ 15.81	\$ 15.81
	2		\$ 31.62	\$ 31.62
	3		\$ 31.62	\$ 31.62
	4		\$ 31.62	\$ 31.62
BCN Mid-Michigan	1	\$ 4.98	\$ 160.12	\$ 165.09
	2	\$ 9.96	\$ 320.23	\$ 330.18
	3	\$ 8.76	\$ 281.80	\$ 290.57
	4	\$ 13.74	\$ 441.92	\$ 455.66
BCN of East Michigan	1	\$ 0.69	\$ 160.12	\$ 160.81
	2	\$ 1.39	\$ 320.23	\$ 321.62
	3	\$ 1.22	\$ 281.80	\$ 283.02
	4	\$ 1.92	\$ 441.92	\$ 443.83
BCN Great Lakes West	1	\$ 46.90	\$ 160.12	\$ 207.01
	2	\$ 93.80	\$ 320.23	\$ 414.03
	3	\$ 82.55	\$ 281.80	\$ 364.35
	4	\$ 129.44	\$ 441.92	\$ 571.36
BCN of SE Michigan	1	\$ 0.42	\$ 160.12	\$ 160.54
	2	\$ 0.85	\$ 320.23	\$ 321.08
	3	\$ 0.75	\$ 281.80	\$ 282.55
	4	\$ 1.18	\$ 441.92	\$ 443.10
Care Choices	1		\$ 159.86	\$ 159.86
	2		\$ 319.72	\$ 319.72
	3		\$ 281.35	\$ 281.35
	4		\$ 441.22	\$ 441.22
Grand Valley Health	1		\$ 153.10	\$ 153.10
	2		\$ 306.20	\$ 306.20
	3		\$ 269.46	\$ 269.46
	4		\$ 422.56	\$ 422.56
Health Alliance Plan	1		\$ 158.17	\$ 158.17
	2		\$ 316.35	\$ 316.35
	3		\$ 278.39	\$ 278.39
	4		\$ 436.57	\$ 436.57

* Health, dental and vision option codes are: 1 = Employee only coverage, 2 = Employee & Spouse, 3 = Employee & Child(ren), 4 = Full Family

Comparison of Dental Care Options

Covered Services	State Dental Plan	DMO Plan	Preventive Dental Plan
Diagnostic Exams and Consultations (2 per year)	100%	100%	100%
Preventive Services <ul style="list-style-type: none"> Teeth cleaning (3 per year) Topical fluoride (under age 19) Space maintainers (under age 14) Sealants (under age 14) 	100% 100% 100% 50%	100% 100% 100% 100%	100% 100% 100% Not Covered
Radiographs	90%	100%	Not Covered
Oral Surgery	90%	100%	100%
Extractions	90%	100%	Not Covered
Minor Restoratives	90%	100%	Not Covered
Major Restoratives	90%	100%	Not Covered
Endodontics	90%	100%	Not Covered
Periodontics	90%	100%	Not Covered
Prosthodontics	50%	100%	Not Covered
Prosthodontics Repair	50%	100%	Not Covered
Orthodontics <ul style="list-style-type: none"> Up to age 19 19 and over 	60% 60%	100% \$1,250 co-pay	Not Covered Not Covered
Benefit Maximums <ul style="list-style-type: none"> Annual (Oct. 2004 – Sept. 2005) Lifetime Orthodontics 	\$1,500 \$1,500	None None	\$1,000 N/A

This benefit summary is a brief explanation only. All plan provisions (including exclusions & limitations) are subject to the specific terms of the State and Preventive Dental Plans and the Group Dental Services Agreement (Midwestern Dental Plans, Inc.).

Organ & Tissue Transplants

	State Health Plan PPO <i>(does not apply to members represented by MSPTA T01)</i>		HMO Benefits
	In-network	Out-of-network	
Bone marrow – specific criteria apply	Covered 100% after deductible in designated facilities	Covered -90% after deductible	Covered 100% in designated facilities
Kidney, cornea, and skin			Covered 100% subject to medical criteria

Other Services

	State Health Plan PPO <i>(does not apply to members represented by MSPTA T01)</i>		HMO Benefits
	In-network	Out-of-network	
Allergy testing and injections	Covered – 100% after deductible	Covered – 90% after deductible	Office visits: \$10 co-pay Injections: 100% covered
Acupuncture	Covered 90% after deductible if performed by or under the supervision of a M.D. or D.O.		Check with your HMO
Rabies treatment after initial emergency room visit	Covered 100% after deductible	Covered 90% after deductible	Office visits: \$10 co-pay Injections: 100% covered
Chiropractic/spinal manipulation	Covered 90% after deductible Up to 24 visits per calendar year		Check with your HMO
Durable medical equipment	Covered – 90% after deductible		Covered 100%
Prosthetic & orthotic appliances			
Private duty nursing			
Wig, wig stand, adhesives	Upon meeting medical conditions, eligible for a lifetime maximum reimbursement of \$300. (Additional wigs covered for children due to growth).		Check with your HMO

Mental Health/Substance Abuse

	State Health Plan PPO <i>(does not apply to members represented by MSPTA T01)</i>		HMO Benefits
	In-network	Out-of-network	
Mental Health Benefits – Inpatient	Covered – 100% up to 365 days per year ²	Covered – 50% up to 365 days per year	Check with your HMO
Mental Health Benefits – Outpatient	As necessary 90% of network rates 10% co-pay	As necessary 50% of network rates	
Alcohol & Chemical Dependency Benefits - Inpatient	Covered 100% ³ Halfway House 100%	Covered 50% ³ Halfway House 50%	
Alcohol & Chemical Dependency Benefits - Outpatient	\$3,500 per calendar year 90% of network rates 10% co-pay ¹	\$3500 per calendar year 50% of network rates	

¹ \$3,500 per calendar year limitation pertains to services for chemical dependency only.

² Inpatient days may be utilized for partial day hospitalization (PHP) at 2:1 ratio. One inpatient day equals two PHP days.

³ Up to two 28-day admissions per year. There must be at least 60 days between admissions. Inpatient days may be utilized for intensive outpatient treatment (IOP) at 2:1 ratio. One inpatient day equals two IOP days.

Prescription Drugs

Prescription medications for the State Health Plan PPO are covered under the Participating Pharmacy ID Card Plan administered by Express Scripts. The co-pays for prescription drugs (both retail and mail order) are based on the employee's bargaining unit. Co-pays are \$7 for generic drugs, \$15 for brand name preferred drugs and \$30 for brand name non-preferred drugs for Non-Exclusively Represented Employees (NERE's), Labor and Trades, Safety & Regulatory Employees represented by MSEA and Institutional employees represented by AFSCME. All other employee co-pays are \$7 for generic drugs and \$15 for brand name drugs. To check the co-pay for drugs you may be taking, visit Express Scripts website at <http://www.express-scripts.com> or contact Express Scripts at (800) 505-2324. The Preferred/Non-preferred list of drugs is updated periodically as new drugs are added.

For information about HMO prescription drug coverage, check with the HMO provider.

Outpatient Physical, Speech, & Occupational Therapy

Combined maximum of 60 visits per calendar year (State Health Plan PPO only)

	State Health Plan PPO <i>(does not apply to members represented by MSPTA T01)</i>		HMO Benefits
	In-network	Out-of-network	
Outpatient physical, speech & occupational therapy – facility and clinic services	Covered – 100% after deductible		Office visit: \$10 co-pay
Outpatient physical therapy – physician's office	Covered 100% after deductible	Covered - 90% after deductible	Office visit: \$10 co-pay

Deductible, Co-Pays and Out-of-Pocket Dollar Maximums

	State Health Plan PPO <i>(does not apply to members represented by MSPTA T01)</i>		HMO Benefits
	In-network	Out-of-network	
Deductible	\$200 per member \$400 per family	\$500 per member \$1,000 per family	None
Co-pays • Fixed dollar co-pays	\$10 for office visits, office consultations, urgent care visits, osteopathic manipulations & medical hearing exams	Not applicable, but deductible and co-pay apply	\$10 for office visits \$50 for emergency room visits, if not admitted
Co-pays • Percent co-pays	10% for DME, prosthetic & orthotic appliances, private duty nursing, chiropractic manipulation & acupuncture	10% for most services	None
Annual out-of-pocket dollar maximums ⁵	\$1,000 per member \$2,000 per family	\$2,000 per member \$4,000 per family	None

⁵ The out-of-pocket limit does not apply to member co-payments for chiropractic.