2020 SOM Employee Benefits Open Enrollment

• Part 1 •

August 3, 2020—August 18, 2020

Contents

BOE Information

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Introducing Benefits Open Enrollment in 2020

This year, Insurance Open Enrollment (IOE) is becoming **Benefits Open Enrollment**! This change is happening for a few reasons. The first is that all benefit plans will be moving to a single consolidated, calendar-based plan year starting January 1, 2021. To facilitate this transition, there will be **two open enrollment periods in 2020.**

BOE Part 1 will be held this summer. Like IOE in previous years, you may change or enroll in all the usual benefits—health, dental, vision, disability, and life insurance—as well as add or remove dependents. BOE Part 1 runs from **August 3, 2020 through August 18, 2020**.

With the shift to calendar-based plan years in 2021 for all benefits, the coverage period for BOE Part 1 elections will last just three months—**October 4, 2020 through December 31, 2020**—as opposed to the traditional 12-month plan year. This shortened coverage period gives employees the opportunity to change their benefit elections sooner than normal if they decide a different plan is a better fit.

BOE Part 2 will take place in the fall from **November 2, 2020 through November 24, 2020**. Benefit elections made during BOE Part 2 will have coverage effective from **January 1, 2021 through December 31, 2021**.

In addition to aligning plan years, a second major change will occur during BOE Part 2. Flexible Spending Account (FSA) Open Enrollment will be combined with enrollment in insurance benefits. This will create a single, comprehensive open enrollment for state insurance and FSA benefits in the fall each year moving forward, with benefit elections effective the following January 1.

During BOE Part 2, a new health insurance option will be introduced: a **High Deductible Health Plan (HDHP) with a Health Savings Account (HSA)**.* An HDHP is a type of health insurance with lower monthly premiums and a higher deductible. An HSA is a tax-advantaged account created for individuals covered under HDHPs to save for medical expenses that HDHPs do not cover (e.g., deductibles and co-insurance). A new **Limited Purpose Health Care FSA** will also be introduced that will only cover dental and vision expenses and is compatible with the HDHP and HSA. HDHP, HSA, and FSA enrollment cannot occur in BOE Part 1 because these plans will not take effect until January 1, 2021.

Much more information will be coming throughout the year to document and explain these changes. The Employee Benefits Division's www.mi.gov/BOE website will house all of the usual open enrollment information you have come to expect, as well as all of the information on the changes happening in 2020 and beyond.

*__Note__: MSPTA-represented employees are excluded from this change.

BOE Dates to Know

BOE Part 1

Enrollment Period: August 3, 2020 through August 18, 2020

Documentation Deadline: September 4, 2020

Coverage Effective Date: October 4, 2020

Coverage Period: October 4, 2020 through December 31, 2020

BOE Part 2

Enrollment Period: November 2, 2020 through November 24, 2020

Coverage Effective Date: January 1, 2021

Coverage Period: January 1, 2021 through December 31, 2021

How to Enroll in Benefits

Online:

Visit the HR Gateway page at www.mi.gov/selfserv and log in to HR Self-Service. Click the "Bookmarks" button in the top-left corner, and hover over "Benefits Open Enrollment" in the drop-down menu. From there, you can choose to start the process of adding new dependents to your benefits or begin the enrollment process.

Over the Phone:

Need help from an HR professional who is trained to help guide you through Benefits Open Enrollment? Call the MI HR Service Center, Monday through Friday, 8:00 a.m. to 5:00 p.m., at **877-766-6447.**

What's New for BOE Part 1?

With all that is happening this year, it's important to stay on top of BOE news. In addition to the BOE Booklet, the Employee Benefit Division's www.mi.gov/BOE website will be your one-stop resource for comprehensive information and details on all things benefits throughout the year.

State Vision Plan: New Polycarbonate Lens Coverage*

Polycarbonate lenses will be a covered in-network benefit under the State Vision Plan and the computer and safety glasses benefit. Light and durable, this additional lens material gives eligible plan members more options and flexibility with their vision care.

State Vision Plan: New Lasik Coverage*

An employee-only $1,000 Lasik reimbursement plan design enhancement will be added to the State Vision Plan. This is a lifetime maximum benefit, and applies only to employees; dependents who are not also benefit-eligible state employees are not covered.

State Dental Plan: Annual Benefit Maximums Changes*

From October 1, 2020 through December 31, 2020, the State Dental Plan's annual benefit maximum will be $1,000. Over a standard 12-month plan year, the maximum is normally $1,500, as it will be in 2021. Starting in 2022, the annual maximum will increase to $2,000.

HMO Health Plans: Deductibles Extended to 15-Month Period

Starting at the BOE Part 1 coverage effective date of October 4, 2020, HMO health plan-enrollees will pay no more in deductibles over the following 15-month period than they would during a 12-month plan year. Deductibles will be waived for the BOE Part 1 plan year (October 4, 2020 through December 31, 2020) and will reset to $125/$250 for individual/full family coverage January 1, 2021.

BOE Part 1 Shortened Plan Year

One benefit of the two BOE windows this year is the shortened plan year of BOE Part 1. Running October 4, 2020 through December 31, 2020, the shorter period gives employees the opportunity to change their benefit elections sooner than normal should they decide a different plan is a better fit.

*__Note__: MSPTA-represented employees are excluded from this change.

Other Eligible Adult Individuals (OEAI)

Enrolling an OEAI and an OEAI's Dependent Children

If you wish to enroll an OEAI in your health insurance, you may enroll via HR Self-Service (www.mi.gov/selfserv) or by calling the MI HR Service Center.* After enrollment you must submit the following documents to the MI HR Service Center* by **September 4, 2020** to complete OEAI enrollment or the added dependent(s) will not be enrolled:

- Enrollment Application and Affidavit (CS-1833)
- Copy of age verification that the OEAI is 18 or older:
    - birth certificate,
    - passport,
    - driver's license, or
    - other governmental document indicating date of birth
- Documents establishing joint residence for the past 12 months (e.g., bank statement, utility bills, etc.). In addition, required documentation must be submitted to maintain enrollment of an OEAI's dependent.

OEAI and OEAI dependent coverage will not take effect if documentation is not received by the MI HR Service Center* by **September 4, 2020.**

Tax Implications

In accordance with IRS regulations, State of Michigan employees are responsible for paying taxes associated with the fair-market value of enrolling an OEAI and the OEAI's dependents. Additional information on OEAI tax implications is available on the Employee Benefits Division web site at www.mi.gov/BOE.

Termination of Benefits

When criteria for enrollment are no longer met, you must notify the MI HR Service Center* within 14 calendar days. Coverage will end effective the date OEAI eligibility criteria are no longer met.

Documentation

*Auditor General and Judicial employees should submit all supporting documentation to their agency HR office.

OEAI Bargaining Group Eligibility

OEAIs are eligible to be added to health plans for all represented and non-represented (NERE) bargaining groups except:
MSPTA and Legislative

Eligibility Guidelines

Eligible Dependents

Eligible dependents may be enrolled in your health, dental, vision, and dependent life insurance plans (an OEAI and their dependents can only be enrolled in health plans). Children by birth or legal adoption or step-children are eligible for dependent life insurance until the day before their 23rd birthday, and eligible for health, dental, and vision insurance through the last day of the month in which they turn 26.

Children for whom the employee has legal guardianship or provides foster care (placed in your home by a state agency or court) are eligible for health, dental, vision, and dependent life insurance until the day before their 18th birthday, unless the placement expires prior to that date.

Note: State-employed married or divorced employees carrying independent enrollments may cover their children in either parent's plan, as long as each child is only covered once. If employees cannot agree which parent will cover the children, the parent who has covered the children first during their employment with the State of Michigan will cover the dependent children.

Note: For a grandchild to be eligible, the parent of the grandchild must be a covered dependent for whom you provide at least 50% financial support AND, if the parent of the grandchild is from 19 up to their 25th birthday, a student as well.

Dependent Life Insurance

Eligible dependents can include your spouse and unmarried children from the age of 14 days up to their 23rd birthday for whom you provide at least 50% of their support. Your spouse is also eligible if they are not a state employee or state retiree.

As a state employee you are automatically enrolled in life insurance. If this coverage is maintained, you are not eligible to be covered as a spouse or dependent on another employee or retiree dependent life insurance plan.

Eligibility Guidelines

Eligibility Exclusions

If you and your retiree or active state employee spouse are both covered by state group insurance plans, you may maintain separate coverage through your individual plans or enroll in one plan with one of you listed as a dependent. If you choose to maintain separate coverage, your children can only be listed as a dependent on one plan. This applies even if you are divorced.

An employee's spouse, OEAI, and dependents are not eligible for coverage if he or she is in the armed forces on active duty. Those individuals are eligible for coverage under TRICARE, effective the date of active duty orders.

Continuing Coverage for Incapacitated Children

Your child who is unmarried and unable to sustain employment because of a developmental or physical disability can continue enrollment in health, dental, vision, and dependent life insurance beyond normal age limits if all the following conditions establishing incapacitated status are met:

- Your child became incapacitated before reaching the age limit for the coverage (age 23 for dependent life insurance and the end of the month in which they turn age 26 for health, dental and vision).
- You have submitted documentation verifying your child's incapacity within 31 days after the child reaches the age limit for termination of the coverage.
- Your child is unmarried and continues to be incapacitated and chiefly dependent on you for support and maintenance.
- Your coverage does not terminate for any other reason.

Canceling Coverage

Immediately notify the MI HR Service Center to cancel your dependent's coverage when he or she no longer meets the definition of an eligible individual. Ex-spouses are not eligible and must be removed from coverage effective the date of the divorce.

Required Documentation

The documents listed in this section are acceptable proof of dependent and OEAI eligibility for insurance coverage. Documents must be provided to the MI HR Service Center by email, fax, or mail. Contact information is provided at the end of this section. Legible copies are required for each type of document. Please do not provide originals; documents will not be returned. Copies of documentation must be faxed or mailed to the MI HR Service Center by **September 4, 2020** or dependent(s) will not be added to coverage.

Life Events

To add or change eligible dependents due to a life event (such as marriage, birth, divorce, etc.), call the MI HR Service Center as soon as possible, but **no later than 31 days following the life event**. Do not wait until you have the official documentation to contact the MI HR Service Center.

Required Documents for Health, Dental, and Vision Coverage

- **Adopted Child**
  - *Adoption Papers* or sworn statement with the date of placement
- **Biological Child**
  - *Birth Certificate* (hospital verifications are not accepted)
- **Foster Child**
  - *Court Document* placing the child in the employee's home for foster care
- **Grandchild**
  - *Birth Certificate* (hospital verifications are not accepted)
  - *Documentation* proving you provide at least 50% support to the parent of the grandchild (e.g., copy of most recent federal 1040 form filed showing the grandchild's parent was claimed as a dependent)
  - **Note:** For a grandchild to be eligible, the grandchild's parent must be a covered dependent AND, from 19 up to their 25th birthday, a student as well as demonstrated by
    - Student Verification of Eligibility Form (CS-1830)
    - *School Records* proving the grandchild's parent is regularly attending an accredited educational institution (e.g., class schedule, transcript)
- **Incapacitated Child**
  - *Birth Certificate* (hospital verifications are not accepted)
  - *Verification Documentation* that the child's condition was confirmed by the insurance carrier before the child reached the usual age limit for coverage
- **Legal Guardianship**
  - *Court-Ordered Letters of Guardianship*

"Required Documents for Health, Dental, and Vision Coverage" continued on next page…

Required Documentation

Required Documents for Health, Dental, and Vision Coverage—Continued

- **Loss of Coverage (for mid-year enrollment)**
  - *Document Detailing Loss of Coverage* from employer or insurance carrier specifying the benefits for which coverage has been lost (e.g., health, vision, dental) and individuals covered
- **Spouse**
  - *Marriage Certificate*
- **Step-Child**
  - *Birth Certificate* (hospital verifications are not accepted)
  - *Marriage Certificate*

Required Documents for Health-Only Coverage

- **OEAI (Other Eligible Adult Individual)**
  - OEAI Enrollment Application & Affidavit (CS-1833)
  - *Joint Residency Documentation* establishing shared residency for the past 12 months (e.g., bank statement, utility bill, lease agreement, etc.
  - *Proof of Age* (birth certificate, passport, driver's license, or other governmental document)
- **OEAI Dependent**
  - OEAI Enrollment Application & Affidavit (CS-1833)

  And any of the four documents below establishing the relationship between the OEAI and the OEAI dependents you wish to enroll:
  - *Birth Certificate* (hospital verifications are not accepted)
  - *Adoption Papers* or sworn statement with the date of placement
  - *Court Document* placing the child in the employee's home for foster care
  - *Court-Ordered Letters of Guardianship*
  - **Note**: Dependent children of an OEAI may enroll in health insurance only up to their 26th birthday with a CS-1833 and the same required documentation that applies to equivalent dependent children of employees. Coverage will terminate at the end of the month in which the dependent turns 26.

MI HR Contact Information

MI HR Service Center Contact Information

Phone: 877-766-6447

Email: MCSC-MIHR-Docs@michigan.gov

Fax: 517-241-5892

Mailing Address:
MI HR Service Center
P.O. Box 30002
Lansing, MI 48909

Note: Auditor General and Judicial employees should submit all supporting documentation to their agency HR office by September 4, 2020.

Documentation Reminder!

Copies of supporting documentation for newly added dependents must be emailed, faxed, or mailed to the MI HR Service Center by **September 4, 2020**

Frequently Asked Questions

Q: Do I need to participate in BOE Part 1 to maintain my benefits?

A: No. As it was with IOE, if you do not make any changes during BOE Part 1, your coverage and covered individuals will remain the same. However, you are strongly encouraged to review your elections to ensure you and your eligible dependents have the necessary coverage for October 4, through December 31, 2020.

Q: Do I need to participate in BOE Part 1 to participate in BOE Part 2?

A: No. BOE Part 1 and BOE Part 2 are two separate enrollment windows and you may participate in either, both, or neither. If you do not make any changes during BOE Part 2, your insurance and covered individuals will remain the same. However, if interested, you will need to enroll in Flexible Spending Accounts during BOE Part 2 for the 2021 plan year.

Q: How is BOE Part 2 different from BOE Part 1?

A: BOE Part 2 will include both FSA Open Enrollment and insurance benefits. BOE Part 2 will also be the first time that insurance plan years will be based on the calendar year.

A High Deductible Health Plan with a Health Savings Account, and the new Limited Purpose Health Care Flexible Spending Account, for dental and vision expenses only, will be offered for the first time during BOE Part 2.

If you wish to enroll in either a Health Care or Dependent Care FSA for the 2021 plan year, you must enroll during BOE Part 2.

After BOE Part 2 concludes, outside of a qualifying life event, your next opportunity to enroll or change your elections will be BOE in the fall of 2021 with a benefit coverage period of January 1, through December 31, 2022.

Frequently Asked Questions

Q. What's an out-of-pocket maximum and how does it work?

A: The annual out-of-pocket maximum (OOPM) is the limit to the total dollar amount you could be required to pay for in-network covered services during the plan year. In-network deductibles, fixed dollar copays, prescription drug copays, and co-insurance all apply towards the annual OOPM.

Once this maximum amount is reached you will not pay any additional co-insurance, deductibles, or fixed dollar copays for in-network covered services for the remainder of the plan year.

The individual OOPM ($2,000) applies to any one family member and the family OOPM ($4,000) is the collective amount that could be paid by any combination of family members. The OOPM is the same for the PPO and all HMOs. Only in-network services apply to the annual OOPM.

Certain charges cannot be used to meet your annual OOPM:

- Out-of-network coinsurance, deductibles, or fixed dollar copays
- Charges for non-covered services or treatments
- Charges in excess of the approved amount the plan pays for a benefit
- Bi-weekly premiums

Q: How does co-insurance work?

A: For services under the SHP PPO, co-insurance is your share of the costs of a covered health care service, calculated as a percent, after your annual deductible is met. For example, for in-network services, if you have met your annual deductible and then have surgery, the insurance plan will pay 90% of the allowed amount for the surgery, and you will pay the 10% co-insurance. All in-network co-insurance charges apply toward the annual in-network out-of-pocket maximum, which limits the amount you can be required to pay for services during a plan year to $2,000 for an individual and $4,000 for a family.

Frequently Asked Questions

Q: How does a deductible work?

A: A deductible is the specified amount you must pay during each plan year for services before your insurance plan begins to pay. The deductible does not apply to all services. Services such as in-network office visits, consultations, and urgent care visits only require a copay at the time of service, and preventive services do not require any copay or deductible. Refer to individual plan summaries at www.mi.gov/EmployeeBenefits for a list of covered in-network services after the deductible.

Your deductible amount will vary based on whether you are enrolled in an HMO or the State Health Plan PPO (SHP PPO). The individual deductible ($400 for the SHP PPO and $125 for an HMO) is the maximum amount that applies to any one family member. The family deductible ($800 for the SHP PPO and $250 for an HMO) is the combined maximum deductible amount that applies to any combination of family members. One family member is not required to reach the individual deductible before that family deductible can be met. Additionally, one family member cannot contribute in excess of the maximum amount of the individual deductible.

Q. Will I pay more in health deductibles due to BOE Part 1's shorter plan year?

A: No. All HMO health plans are waiving in-network deductibles during the BOE Part 1 plan year of October 4, 2020 through December 31, 2020. Normal in-network deductible accumulations will reinstate on January 1, 2021.

Enrollees in the State Health Plan PPO receive a fourth-quarter carryover. In-network deductible amounts paid between October 4, 2020 through December 31, 2020 will be applied to the in-network deductible of the 2021 plan year. This carryover does not apply to the 2021 plan year's out-of-pocket maximum.

Regardless of the health plan, enrolled employees will pay no more for in-network deductibles over the course of this 15-month period covered by the BOE Part 1 and BOE Part 2 plan years than they would have paid over the course of a traditional 12-month plan year. The next page includes examples of how this will work.

Understanding BOE Part 1 Deductible Costs

Health Maintenance Organization (HMO) Deductible Example:

Jacob receives in-network services on November 18, 2020 for a benefit that is covered 100% after deductible (e.g., ambulance services, x-rays, MRI, etc.). The provider submits a claim to the HMO carrier for an allowed amount of $550. As a result of the in-deductible deductible waiver for the BOE Part 1 coverage period, the HMO carrier will issue payment to the provider for 100% of the allowed charges ($550) and Jacob's in-network member cost share will be $0.

Jacob receives the same in-network services again on February 18, 2021. The provider submits a claim to the HMO carrier for an allowed amount of $550. Because the HMO in-network deductible ($125 per individual/$250 per family) is in effect for the BOE Part 2 coverage period, the HMO carrier will issue payment to the provider for $425 and the provider will send a bill to Jacob for his member cost share of $125.

State Health Plan PPO Deductible Example:

Jacob receives in-network services on November 18, 2020 for a benefit that is covered 90% after deductible (e.g., ambulance services, x-rays, MRI, etc.). The provider submits a claim to BCBSM for an allowed amount of $550. BCBSM verifies that Jacob's in-network deductible accrual for the coverage period is currently $0. BCBSM will subtract the deductible ($400) from the allowed amount and send payment to the provider for 90% of the remaining balance ($135). The provider will send a bill to Jacob for his in-network member cost share of $415 (deductible + 10% co-insurance).

Jacob receives the same in-network services on February 18, 2021. The provider submits a claim to BCBSM for an allowed amount of $550. BCBSM verifies that Jacob's current in-network deductible accrual for the coverage period is $400 due to the services received on November 18, 2020 and 4th quarter carryover. BCBS will send payment to the provider for 90% of the allowed amount ($495). The provider will send a bill to Jacob for his member cost share of $55.

Insurance Carrier Information

State Health Plan PPO–Blue Cross Blue Shield of Michigan (BCBSM)

State Catastrophic Health Plan–Blue Cross Blue Shield of Michigan (BCBSM)

BCBSM State of Michigan Service Center

Phone: 800-843-4876

www.bcbsm.com/som

HMOs—Health Maintenance Organizations

Blue Care Network

Phone: 800-662-6667

www.bcbsm.com/som

Health Alliance Plan (HAP)

Phone: 800-422-4641

www.hap.org

McLaren Health Plan

Phone: 888-327-0671

www.mclarenhealthplan.org

Physicians Health Plan (PHP)

Phone: 800-832-9186 or 517-364-8500

www.phpmichigan.com

Priority Health

Phone: 800-446-5674

www.priority-health.com/som

Insurance Carrier Information

State Health Plan PPO Prescription Drug Program

OptumRx: Active Employees & Non-Medicare Retirees
Phone: 866-633-6433

OptumRx: Medicare-Eligible Retirees
Phone: 866-635-5941

www.optumrx.com/som

State Health Plan PPO Behavioral Health/Substance Abuse Services

BCBSM in partnership with New Directions
Phone: 866-503-3158
www.bcbsm.com/som

COPS Health Trust Plans (MSPTA-Represented Employees Only)

COPS Health Trust
Phone: 800-225-9674 or 248-524-0454
www.copstrust.com

State Dental Plan and Preventive Dental Plan

Delta Dental Plan of Michigan
Phone: 800-524-0150
www.deltadentalmi.com/som

State Vision Plan

EyeMed
Phone: 833-279-4355
www.eyemedvisioncare.com/som

State Long Term Disability (LTD) Plan

Sedgwick
Phone: 800-324-9901

HIPAA Exemption Notice

Under a federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits state and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The State of Michigan has elected to exempt the State of Michigan State Health Plan PPO from the following requirements:

Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan. The exemption from these federal requirements will continue to be in effect for the period of plan coverage beginning October 4, 2020, and ending December 31, 2020. The election may be renewed for subsequent plan years.

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a pre-existing condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy. As required by state law (MCL 550.544), notice is provided that, as a rider under your health coverage, elective abortion is included and may be used by a covered dependent without notice to the employee.

Special Enrollment Rights

If you decline to enroll because you have other health coverage, and you or your dependent loses eligibility for the other coverage or the employer stops contributing towards the coverage, you may be able to enroll in this plan. However, you must request enrollment within 31 days after you or your dependent's other coverage ends or after the employer stops contributing toward the other coverage.

Special enrollment is also available to (1) those who become eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP) and (2) those who lose coverage under Medicaid or CHIP because they are no longer eligible, not because of non-payment. The deadline for these two enrollments is 60 days after eligibility or termination.

To request special enrollment or obtain more information, contact the MI HR Service Center.

For Questions about HIPAA Exemption:

Contact the Employee Benefits Division at:

800-505-5011

HIPAA Privacy Notice

The HIPAA Notice of Privacy Practices for the benefit plans is available on the Civil Service Commission web site at:
http://www.michigan.gov/documents/HIPAA_Plans_Privacy_Notice_61312_7.pdf