2019 State of Michigan Employee

Insurance Open Enrollment

August 1, 2019–August 23, 2019

Contents

IOE Information

Rates

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IOE 2019 Calendar

August

1st–Insurance Open Enrollment Begins

23rd–Insurance Open Enrollment Ends

September

30th–Deadline to submit documentation to MI HR for newly-added individuals

October

6th–2019-2020 plan year begins; new rates and elections take effect

17th–First earnings statement with 2019-2020 rates and elections

How to Enroll in Benefits During IOE

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 "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 Insurance Open Enrollment? Call the MI HR Service Center, Monday through Friday, 8:00 a.m. to 5:00 p.m., at **877-766-6447.**

Should I Participate?

- "I want to **make changes** to my current benefit elections."
- "I want to **add** or change someone's coverage on my health, dental, vision, or life insurance."
- "I want to **enroll** in disability insurance."
- "I want to **review** my current coverage."
- "I want to **update** the beneficiaries for my life insurance online."

If any of these statements sound like you, then you should participate in IOE this year!

Visit the HR Gateway page at www.mi.gov/selfserv to log in to HR Self-Service and enroll online or contact the MI HR Service Center at 877-766-6447.

Insurance Open Enrollment is your annual opportunity to change your benefit elections (health, dental, vision, life, and disability insurance). You are strongly encouraged to review your elections to ensure you and your covered eligible dependents have the necessary coverage for the coming year.

If you do not make any changes, your coverage and covered individuals will remain the same.

What's New for IOE 2019

IOE only comes once a year, so it's important to stay on top of the news. All the updates can be found here and on the 2019-2020 IOE Plan Changes web page.

Dental and Vision Eligibility Guideline Changes

Effective October 6, 2019, dependent eligibility guidelines for dental and vision insurance will align with health insurance, meaning adult children will be eligible to remain on your coverage through the end of the month in which they turn age 26. IOE is your opportunity to add dependents to your dental and vision insurance if they are not currently covered. Prior to October 6, 2019, eligibility of dependent children follows the current Dependent Eligibility Guidelines.

New Behavioral Health & Substance Abuse Administrator

Effective October 1, 2019, Blue Cross Blue Shield of Michigan, in partnership with New Directions, will be replacing Magellan Health as the State Health Plan (SHP) PPO Behavioral Health/Substance Abuse carrier. Current SHP PPO enrollees will be automatically transitioned with no gap or changes in coverage. New SHP PPO membership ID cards will be mailed in September.

State Vision Plan: Increased Frame Allowance*

Under the State Vision Plan, administered through EyeMed, eyeglass frames allowances under the routine vision and computer glasses benefit will increase from $100 to $150.

Telemedicine Copay Reduction*

Under the SHP PPO and all HMO health plans, telemedicine copays will be reduced from $20 to $10.

UnitedHealthcare HMO Not Offered

On October 6, 2019, UnitedHealthcare will no longer be an offered HMO option. If you were previously enrolled in UnitedHealthcare and want to continue health coverage, please ensure you elect new health coverage during IOE.

New COPS Health Trust Plan

For MSPTA-represented employees only, a new COPS Health Trust plan is being offered. Visit the Insurance Plans page for a plan summary and more information regarding COPS Health Trust Plan 4.

Insurance Rate Changes:

Be sure to review the insurance rates as nearly all have changed.

*__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 30, 2019** to complete OEAI enrollment or the added dependent(s) will be removed from coverage:

- 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 30, 2019.**

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/IOE.

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 Deadline

All Insurance Open Enrollment documentation must be received by the MI HR Service Center by

September 30, 2019

OEAI Bargaining Group Eligibility

OEAIs are eligible to be added to benefit plans for all represented and non-represented (NERE) bargaining groups except: **MSPTA, Judicial, and Legislative**.

Eligibility Guidelines—Part 1 of 2

Eligible Dependents

Eligible dependents may be enrolled in your health, dental, vision, and dependent life insurance plans (OEAI and their dependents can only be enrolled in health plans). Children by birth, 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 age 26.

Children the employee has legal guardianship of or 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 an unmarried covered dependent for whom you provide at least 50% financial support AND, if the parent of the grandchild is between the ages of 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 or retiree, 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—Part 2 of 2

Eligibility Exclusions

If you and your retiree or active 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—Part 1 of 2

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 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 30, 2019** 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 an unmarried covered dependent AND, from 19 up to their 25th birthday, a student as well
    - 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—Part 2 of 2

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
Fax: 517-241-5892

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

Note: Legislative, Judicial, and Auditor General must submit required documentation to their respective Human Resource Office by September 30, 2019.

IOE Reminder!

Copies of documentation must be faxed or mailed to the MI HR Service Center by **September 30, 2019**.

Frequently Asked Questions

Q: How does a deductible work?

A: A deductible is the amount you must pay for some covered health care 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 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), as well as how many people are covered by your plan and how many of them seek services. The individual deductible applies to any one family member. The family deductible ($800 for the SHP PPO and $250 for an HMO) is the combined amount that could be paid by any combination of family members, as long as one individual has reached the individual deductible.

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 covered services during the plan year. In-network deductibles, fixed dollar copays, prescription drug copays, and co-insurance all apply towards this annual out-of-pocket limit. Once this maximum amount is reached you will not pay any additional co-insurance, deductibles, or copays for 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 combined amount that could be paid by any combination of family members. The OOPM is the same for the PPO and all HMOs.

The OOPM does not include:

- Bi-weekly premiums
- Charges above the allowed amount the plan pays for a benefit
- Charges for non-covered services or treatments
- Charges for out-of-network services or treatments

Q: How does co-insurance work?

A: For in-network 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, 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 co-insurance charges apply toward the annual out-of-pocket maximum, which limits the amount you can be required to pay for services during a plan year to $2000 for an individual and $4000 for a family.

Understanding State Health Plan PPO Costs

Example of Deductibles, Co-Insurance, and Out-of-Pocket Max

Example 1: Total Cost of an In-Network X-Ray

A State employee and her family are enrolled in the State Health Plan PPO. When the plan year* started, the employee received an X-ray. According to the plan, this is an after-deductible service with a co-insurance of 10%. What would she pay for this service?

Employee Cost	Plan Cost
$400 - Annual Individual Deductible **+** **10%** Co-Insurance	**90%** of the remaining cost after the annual individual deductible is met.

Note: If an employee's spouse or dependent never receive deductible-applicable services during the plan year, only the individual deductible of $400 would need to be met. The same is true if a dependent or spouse seeks deductible-applicable services and the employee does not; only the individual deductible would apply.

Example 2: Total Cost of an In-Network Surgery

The same State employee's spouse needed surgery shortly after. According to the plan, surgery (in-network) is an after-deductible service with a co-insurance of 10%. What would they pay for this service?

Employee Cost	Plan Cost
$800 - Annual Family Deductible **+** **10%** Co-Insurance	**90%** of the remaining cost after the annual individual deductible is met.

Note: If a spouse (or dependent) was the only individual to receive deductible-applicable services during the plan year, only the annual individual deductible of $400 would need to be met. In this case, since both the employee and spouse received deductible-applicable services, the entire $800 family deductible would need to be met before the plan paid for the spouse's surgery.

Example 3: Total Cost of an In-Network Surgery

During the plan year, the same State employee has paid the $2,000 out-of-pocket annual maximum for her **individual** deductibles, co-insurance, and prescription copays and now needs a surgery. What would she pay for this service?

Employee Cost	Plan Cost
$0	**100%** The plan will pay the total approved amount for this surgery as she paid the annual maximum amount for out-of-pocket expenses for the plan year.

*Deductible amounts for the State Health Plan PPO renew annually each January.

Note: Any amount you accumulate toward your in-network deductible for dates of service during the fourth quarter of each year (October through December) will carry over and be applied to your in-network deductible the following year. This carryover does not apply to the following year's out-of-pocket maximum.

How Do HMO Costs Work?

Example of Deductibles and Out-of-Pocket Max

(HMOs do not carry co-insurance)

Example 1: Total Cost of an In-Network X-Ray

A State employee and her family are enrolled in an HMO. When the plan year* started, the employee received an X-ray (in-network). According to the plan, this is an after-deductible service. What would she pay for this service?

Employee Cost	Plan Cost
$125 Annual Individual Deductible	**100%** of the remaining cost after the annual individual deductible is met.

Note: If the employee's spouse or dependents never receive deductible-applicable services during the plan year, only the individual deductible of $125 would need to be met. The same is true if a dependent or spouse seeks deductible-applicable services and the employee does not; only the individual annual deductible would apply.

Example 2: Total Cost of an In-Network Surgery

The same State employee's spouse needed surgery shortly after. According to the plan, surgery (in-network) is an after-deductible service. What would they pay for this service?

Employee Cost	Plan Cost
$250 Annual Family Deductible	**100%** of the remaining cost after the annual family deductible is met.

Note: If a spouse (or dependent) was the only individual to receive deductible-applicable services during the plan year, only the annual individual deductible of $125 would need to be met. In this case, as both the employee and spouse received deductible-applicable services, the entire $250 annual family deductible would need to be met before the plan paid for services.

Example 3: Total Cost of an In-Network Surgery

During the plan year, the same State employee has paid the $2,000 out-of-pocket annual maximum for her **individual** deductibles and prescription copays and now needs a surgery. What would she pay for this service?

Employee Cost	Plan Cost
$0	**100%** The plan will pay the total approved amount for this surgery as she paid the annual maximum amount for out-of-pocket expenses for the plan year.

*Deductible amounts for HMOs renew annually each October.

Insurance Carrier Information—Part 1 of 2

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—Part 2 of 2

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

State Dental Plan and Preventive Dental Plan

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

Dental Maintenance Organization (DMO)

Midwestern Dental Plans, Inc.
Phone: 800-544-6374
www.midwesterndental.com

State Vision Plan

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

State Long Term Disability (LTD) Plan

York.
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 6, 2019, and ending October 3, 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